An exploration of Muslims' perceptions and experiences of mental health, illness and treatment services

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Statement of Original Authorship

This thesis contains no material published elsewhere or extracted in whole or in part from a thesis by which I have qualified or been awarded another degree or diploma.

No parts of this thesis have been submitted towards the award of any other degree or diploma in any other tertiary institution.

No other person's work has been used without due acknowledgment in the main text of the thesis.

All research procedures reported in this thesis received the approval of the relevant Ethics/Safety Committees (where required).

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Abstract

This research involves an exploration of Muslims' attitudes, perceptions and experiences of mental health and accessing professional treatment services. It utilised a mixed-methods design consisting of in-depth interviews and a survey. The face-to-face interviews were conducted with practising Muslims in Australia (n = 20), Indonesia (n = 8) and Jordan (n= 6). The online survey was based on the main themes which emerged from the interviews and was completed by Australian Muslim participants (N = 200). Grounded theory was employed as the underlying approach for the qualitative data collection and analysis.

The results revealed three main findings. First, that Islam was central to the participants' lives functioning as a sacred lens and sacred compass. The lens and compass provided a way for them to connect with Islamic beliefs, values and perspectives each day. This was relevant to their mental health, approaches to coping, and perspectives of effective treatment. Second, that the participants adopted distinct help seeking pathways which involved a range of religious and cultural influences. Third, the participants highlighted a need for religiously and culturally appropriate treatment for Muslim clients.

In view of providing religiously and culturally appropriate treatment, key areas were identified in order to engage Muslim clients. This consisted of an underpinning knowledge of basic beliefs and practices, understanding relevant religious coping responses, and understanding the role of culture, community and family. The findings highlighted the importance of practitioners building a therapeutic relationship through trust and respect with their Muslim clients. Overall, the findings draw attention to the need for theorists, researchers and clinicians to incorporate religious perspectives of mental health and its treatment, particularly when working with Muslim clients.

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Chapter 1

Introduction: Context and Purpose

In the years since the September 11 attacks, Muslims and Islam have been subject to increased scrutiny in Australia, as is the case in other Western nations (Bloemraad, Kortewag & Yurdakul, 2008; Poynting & Mason, 2006). Contemporary issues associated with Muslims, such as international terrorist attacks and asylum seekers fleeing to the West, have continued to drive a mixture of both interest and fear about Muslims and the religion of Islam (Aly, 2010; Morgan & Poynting, 2012; Poynting & Mason, 2007). Some commentators observe that as a result of the spotlight on Muslims, they have been constructed as "other" in the West through media representations and political discourse (Bonn, 2010; Morgan & Poynting, 2012; Poynting & Mason, 2007; Poynting & Perry, 2007). This was particularly evident in the years immediately after September 11 as media reports were often characterised by an "us" versus "them" dichotomy, fuelled by rhetoric associated with the "war on terror" (Aly, 2010; Ata, 2016; Manning, 2004; Poynting & Mason, 2007; Said, 1997). The concept of "othering" refers to the creation of a power differential by positioning one group as fundamentally different or alien in relation to existing social norms (Davies, 2004; Hall, 2003; Khawaja & Morck, 2009; Wilkinson & Kitzinger, 1996). The process of "othering" in relation to Australian Muslims, as postulated by Yasmeen (2010), denotes that references towards Muslims suggest either explicitly or implicitly that they are different and therefore not part of the wider Australian society.

According to a report by the Anti-Discrimination Board of New South Wales (ADB, 2003) a "moral panic" about Muslims and Islam in Australia has resulted from a combination of the international "war on terror", Australia's policies regarding asylum seekers, and the negative representations of Arabs and Muslims perpetuated by print, radio and television

news media. Various studies have confirmed the disproportionate number of negative representations of Muslims in the Australian media. For example, Manning's (2004) content analysis of the two major Sydney daily newspapers found that news articles tended to have a high proportion of negative terms and connotations associated with Muslims and Islam, such as "extremist", "fundamentalist", and "terrorist". News reports on Muslims were found to focus on the potential threat of Muslim extremism and concerns regarding the compatibility of Islam with Western values. These findings are consistent with international portrayals of Muslims and Islam in the media (Ahmed & Matthes, 2016).

Following the 2005 bombings in London, the concept of "home-grown terrorists" heightened concerns about the possibility of the dangers of an "enemy from within" amongst Australian Muslims (Yasmeen, 2010). In recent years, terror attacks in Western countries carried out by citizens of those nations have continued to fuel this fear. In the wake of such events, rhetoric from some political leaders has emphasised the threat of Islam in Western societies. For example, following an attack in London in March 2017 an Australian senator, Pauline Hanson, stated that "Islam is a disease, we need to vaccinate ourselves against that" (Remeikis, 2017). Poynting, Noble, Tabar and Collins (2004) assert that negative references to and representations of Muslims and Islam have fuelled acts of discrimination, abuse, violence and exclusion towards Muslims in Western societies, including Australia.

Indeed, studies consistently confirm that Muslims in Australia experience high levels of racism, particularly since September 11 (Dunn, Atie, Mapedzahama, Ozalp & Aydogan, 2015; HREOC, 2004; IWWCV, 2008). One Australian study into racism and exclusion directed towards Arabs and Muslims found that two thirds of participants had experienced increased racism since 11 September 2001 and 93% believed that there had been an increase in racism directed towards them (Noble & Poynting, 2007). As a result of experiences of racism and discrimination, Australian Muslims have reported feeling a sense of

marginalisation within the broader society (HREOC, 2004; IWWCV, 2008; Ryan, & McKinney, 2007). This is concerning, particularly as research shows that experiences of exclusion and marginalisation can result in negative outcomes for minority groups. This includes poorer mental health, which can be particularly problematic if minority groups are also reluctant to engage with mental health services (Brondolo, Ng, Pierre, & Lane, 2016; Whittaker, Hardy, Lewis & Buchan, 2005; WHO, 2012). Despite these risk factors, key data concerning the mental health of Muslims in Western countries, such as the prevalence of mental illness, is lacking.

The positioning of Muslims as "other" (Spivak, 1985) is likely to serve as a barrier to understanding their viewpoints, concerns, and experiences in Western societies. Indeed, studies show that Muslims perceive that their communities and religion remain largely misunderstood by the broader Australian society (Dunn et al., 2015; HREOC, 2004). Researchers such as Khawaja (2016) assert that there is a need for research which provides deeper insights regarding Muslims in order to address misconceptions and misunderstandings about their lives and religion. Similar recommendations have been put forward in a range of reports on Muslims in Australia (Dunn et al., 2015; HREOC, 2004; IWWCV, 2008; Ryan, & McKinney, 2007). These recommendations suggest a need for research which gives voice to the perspectives and viewpoints of Muslims.

The Gap in the Research

The contemporary socio-political climate in Australia exposes Muslims to a range of stressors and inequalities. These include discrimination, stigmatisation, social isolation, threats to identity, substantive cultural adjustment and lower socio-economic status (Dunn, Forrest, Burnley, & McDonald, 2004; HREOC, 2004; IWWCV, 2008; Kalek, Mak &

Khawaja, 2010; Khawaja, 2007; WHO, 2012). Such factors place Muslims at substantial risk for mental health problems.

There has been a growing acknowledgement of the mental health impacts of recent events involving Muslims and the need for research which investigates Muslims' mental health. As a result, there have been some advances to address the gap. This includes a gradual increase in the number of studies performed on a range of issues relating to Muslims and their mental health (e.g., Abu-Raiya, 2013a; Walpole, McMillan, House, Cottrell, & Mir, 2013). Furthermore, the founding of the *Journal of Muslim Mental Health* in 2010 reflects a recognition of the need to investigate issues relating to Muslims' mental health around the world.

Whilst these developments indicate that there is progress in investigating issues pertinent to Muslims and their mental health, the available research is limited. Further, there are a number of limitations with the available literature, such as limited phenomenological inquiry of Muslims and their mental health (e.g., Abu-Ras & Abu-Bader, 2008; Aloud & Rathur, 2009; Eltaiba & Harries, 2015; Ribeiro & Saleem, 2010). There is also scant literature which provides comparisons of mental health between Muslims living in Western societies and those living in majority-Muslim societies. There is a particular dearth of research which investigates Muslims' mental health in Australia. Despite numerous identified risk factors faced by the Australian Muslim community (Dunn, et al., 2004; HREOC, 2004; IWWCV, 2008; Kalek, et al., 2010; Khawaja, 2007; WHO, 2012) there has been limited research regarding their perspectives and experiences of mental health problems. Additionally, it is not known whether the findings from other countries are generalisable to Muslims in Australia. Although Muslims across the world share common beliefs and practices based upon Islam, they are also highly heterogeneous. As such, Muslim communities around the globe may differ in important ways due to the influence of the social,

political and cultural context in which they reside. Comparative studies are therefore needed to explore the similarities and differences between Australian Muslims' mental health and other Muslim populations around the world.

Due to the limited research about Muslims and their mental health, particularly in Australia, mental health practitioners treating Muslims may lack an understanding of the ways in which Islam influences their lives, in regard to their mental health. This lack of research is likely to have an impact on practitioners in their efforts to tailor services appropriately for Muslim clients. Therefore, a significant problem in meeting the needs of the Australian Muslim community in the context of mental health services is the lack of research to inform assessment, interventions and outcomes.

Research is needed which explores the ways in which Muslims in Western countries such as Australia and Muslims in majority-Muslim countries perceive and respond to their mental health problems, the manner in which their faith and identity impact upon their coping responses and choices of treatment, and the factors which facilitate, and inhibit, their help-seeking behaviours. There is a need for research in key areas for Muslims, including the relationships between mental health and immigration, acculturation, discrimination, and other stressors, as well as studies on treatment effectiveness for Muslim clients. The lack of research, coupled with reports that Australian Muslims consider that Islam and Muslims are generally misunderstood by the broader community (Dunn et al., 2015; Hopkins, 2011; HREOC, 2004), suggest that qualitative research would be of particular value. Qualitative methods can provide researchers with deep insights into the lives of Muslims and their perspectives and experiences of mental illness. This can offer a rich source of data to understand areas of commonalities and convergences (Thyer, 2010). Utilising a comparative approach is highly beneficial in exploring the perspectives and experiences of Muslims. Comparing the groups of Muslims from both majority-Muslim and minority-Muslim contexts

allows for the identification of themes and concepts which cut across different ethnic, cultural and social influences.

Understanding the perspectives and experiences of Muslims in Australia is consistent with trends in the area of mental health towards being cognisant of the needs of minority groups. In recent decades, there has been a growing recognition that mental health services need to account for cultural contexts and religious values relevant to client wellbeing (Griner & Smith, 2006; Whitley, 2012). The increasing cultural diversity of Western nations has highlighted the need for practitioners to be competent in providing services to minority groups (Berry, Phinney, Sam, & Vedder, 2006; Nassar-McMillan, 2014).

Research Significance

This thesis addresses a gap in the literature by focusing on the perspectives and experiences of Muslims in relation to their mental health. This research is valuable as it seeks to understand Muslims' perspectives of mental health and illness, the way that Islam informs their view, their coping responses and their experiences in accessing treatment for mental health problems. The focus is on Australian Muslims however, the research is distinctive as it includes a comparative analysis of Muslims across three countries in order to understand how their perspectives and experiences of mental health are similar or different. For this purpose, the views and experiences of Muslims residing in Australia and in the majority-Muslim countries of Indonesia and Jordan were investigated. This diversity provided for a range of Muslims' voices to be heard.

This research is among the few studies of Muslims and their mental health utilising a grounded theory methodology. The use of grounded theory is a strength as the process aims to inductively identify key concepts grounded in the data and present the views and experiences of the participants as closely as possible to the ways in which they perceive them.

A potential benefit of this research includes increasing the broader society's understanding of Muslims and the role of Islam in their lives, thereby reducing the perception of this community as "other". This research provides an opportunity to gain an understanding of Muslims' mental health needs and the findings may be used to develop effective approaches to better meet these needs.

Research Methodology

The current research adopted a predominantly qualitative approach. Qualitative methods were considered to be the most appropriate as they provide a phenomenological view of the phenomena under investigation (Charmaz, 2006). Due to the "othering" of Muslims in public discourse (Yasmeen, 2010), the research required methods which would "give voice" to the participants and seek to understand their perspectives. Qualitative methods allow for open-ended, exploratory processes, which are helpful to understand the meanings which participants assign to their experiences. Grounded theory was selected as it provides a structured set of processes to perform inductive investigations where there is a substantive lack of research (Charmaz, 2006).

Research Process

Like many other types of research, grounded theory provides a conceptual overview of social phenomena that can be applied to other relevant people or situations (Glaser, 1992). However, the inductive nature of grounded theory is particularly suited to the aim of the research, which is to present the views of Muslims as closely as possible to the ways in which they perceive them. Grounded theory researchers strive to embark upon the research process without a preconceived idea of what will be found, rather aiming to uncover the participants' main concerns from the data (Charmaz, 2006). The constructivist viewpoint of grounded theory employed in this research diverges from the positivist assumptions of the early

versions of grounded theory to acknowledge that the researcher cannot be an entirely neutral observer (Charmaz, 2000; 2006). However, the aim is to present the perspectives, attitudes and experiences of Muslims towards mental health and treatment services as close as possible to the meanings intended by the participants.

Structure of the Thesis

The thesis includes a further seven chapters. Chapter 2 presents a brief description of Islam and an overview of key information about Muslims in Australia. In Chapter 3 a review of literature which is pertinent to Muslims and their mental health is provided. This chapter highlights the limited investigations available regarding Muslims and their mental health, and outlines a gap in the literature pertaining to in-depth, qualitative research of Muslims' perspectives and experiences of mental health and illness, their coping responses, and their needs in relation to treatment. An overview of the methods utilised in the research is given in Chapter 4. This includes the aims, the research design, the methodological approach and a justification for the methods adopted. The chapter includes a discussion of the development of grounded theory and outlines the chosen approach for this research, constructivist grounded theory as described by Charmaz (2000, 2005, 2006). The next three chapters describe the results of the study with each elaborating a key theme which was identified across the data. Specifically, Chapter 5 presents the findings in relation to the role of Islam in the participants' day-to-day lives. This includes an exploration of the ways in which Islam shapes their perspectives of mental health and illness, the role of Islam in their wellbeing and in their coping responses to mental health problems. Chapter 6 presents the findings in terms of the help-seeking pathways of the participants. This chapter provides a conceptual framework to identify the stages of recognising and responding to mental health problems. Importantly, this chapter explores barriers in seeking professional mental health treatment. Chapter 7 presents key areas of knowledge and practice for religiously and culturally

sensitive treatment to Muslim clients. This framework is based upon the reflections of the participants regarding their perspectives and experiences of mental health treatment.

Finally, Chapter 8 provides a discussion of the main findings in relation to the literature and the clinical implications for the provision of treatment services to Muslim clients. This chapter includes an examination of the strengths and limitations of the research, as well as recommendations for further research.

Chapter 2

A Broad View of Islam and Muslims in Australia

This chapter outlines information about the religion of Islam, providing an overview of its beliefs and practices. This is followed by a brief history of Muslims in Australia, including their history of settlement and their demographic characteristics. The chapter also highlights the range of inequalities faced by Australian Muslims, which represent risk factors for mental health problems.

Islam: Basic Beliefs and Practices

Islam is the second largest religion in the world with approximately 1.8 billion followers (Pew Research Centre, 2015). It is one of the three Abrahamic faiths, alongside Judaism and Christianity. Approximately 20% of the world's Muslims reside in the Middle East and North Africa. The most populous Muslim-majority country is Indonesia, which has 12.7% of the world's Muslims, followed by Pakistan which has 11%, Bangladesh (9.2%) and Egypt (4.9%) (Pew Research Centre, 2009). Muslims are therefore highly diverse culturally, linguistically and ethnically which provides varied influences in their lives. The cultural influences tend to be distinct from religious influences, which are based in sacred texts.

Muslims believe in one God (Allah, who is the one, single God and is considered to be the same God that is worshipped by the Jews and Christians) who sent prophets and messengers to mankind, from Adam, the first prophet, to Muhammad, the last. Muslims believe that revelations were sent by God to the prophets for the guidance of mankind. These include the Torah, the Gospel and the Holy Quran, which is the final scripture revealed to Prophet Muhammad over a 23-year period from 610 to 632 (Nigosian, 2004).

Muslims follow two main sources of Islamic guidance, the Quran, which is regarded as the unalterable and perfect words of God, and prophetic traditions, which are the stories, sayings and

deeds of Prophet Muhammad (*hadeeth*) (Nigosian, 2004). Muslims read the Quran daily in their prayers and consult verses of the Quran and *hadeeth* when making personal and family decisions (Maqsood, 2008). The Arabic word 'Islam' means 'submission' or 'surrender' to Allah and so followers believe that they must surrender their will, in both body and mind, to God in all matters throughout their day. 'Islam' is also connected to the Arabic word *salam*, meaning 'peace', indicating that one attains peace and harmony when submitting one's will to God (Abu-Raiya, 2013a).

Islam sets out six articles of faith that all Muslims are required to believe; One God, prophets, divine revelation (including the Gospel, Torah and the Quran), angels and other unseen beings such as *jinn* (spirits), preordained destiny, and judgment day and the afterlife. Along with angels and *jinn*, Islamic beliefs include supernatural phenomena such as *sihr* (black magic) and *ayn* (evil eye) (El-Zein, 2011).

There are five fundamental practices, or pillars, of Islam. The first is making the *shahaada*, the testimony of belief in Allah as the one and only God, and Muhammed as the final messenger. Declaring this testimony of faith with conviction is the only requirement for a person to become a Muslim and is repeated by Muslims in their supplications and ritual prayers. Second, the five daily prayers are performed at prescribed times throughout the day; before day-break, after midday, in the afternoon, at dusk, and at night. The daily prayers are considered to be obligatory acts of worship. Third, paying *zakah*, or an alms tax of 2.5% of one's capital assets for the poor and needy (Turner, 2011). The word *zakah* means purification in Arabic and is part of fulfilling an obligation in the Muslim community to help those in need. Fourth, fasting during the month of Ramadan, which is an obligation for healthy and physically-able adults. During the month of Ramadan Muslims abstain from food, drink and sexual intercourse in the daylight hours until the fast is broken at dusk. Ramadan is considered to be a holy month and during this time Muslims often increase their acts of worship, prayers and supplications. Fifth, the *hajj*, or

pilgrimage to Mecca, is an obligation upon Muslims at least once in their lifetime provided that health and finances permit (Turner, 2011). The rites of *hajj* include circling the *Kaba* (a building in Mecca believed to be originally constructed by the prophet Abraham on God's orders), running seven times between the two hills named *Safa* and *Marwa* according to the story of Abraham's wife Hagar who did so when searching for water for their son Ishmael, and standing at the mountain of *Arafat* to supplicate and ask for forgiveness (Turner, 2011).

Muslims believe that the ultimate destination of paradise in the next life will be a reward for adhering to the tenets of Islam and living a moral life according to the Quran and *hadeeth*. Therefore, life is considered to be a test of whether one will obey God and follow guidance provided through the prophets. Muslims also believe in sin and repentance; sins are actions or intentions forbidden by God that are hurtful to oneself or harmful to others. These include pride and arrogance, gossiping and slander, lying and theft, murder, adultery, disrespect of parents, greed, oppression of the poor, abuse of others, and negligence in performing the five pillars of Islam (Gordan, 2009; Nigosian, 2004).

Islam offers a complete way of life for its followers. The Islamic system provides beliefs and perspectives for the meaning of life, and contains detailed directions for life affairs, from major life events to mundane daily tasks (Ramadan, 2006). Islam contains rulings on boundaries in daily affairs which are defined in terms of being either *halal* (permitted) or *haram* (forbidden). The concepts of *halal* and *haram* are often associated with food and drink, however, these boundaries also pertain to other issues, such as social and interpersonal relations, work, study, marriage, and financial transactions. Muslims are aware of the rulings of general permissibility which usually fall into the categories of *halal* or *haram*. For example, practising Muslims generally seek *halal* food (i.e., allowable foods such as meat slaughtered according to Islamic law) and avoid eating food which is considered *haram* (e.g., pork or pork products, alcohol). Other areas of permissibility exist for those that have more in-depth knowledge of the faith, such

as *waajib* or *fard* (obligatory), *mustahabb*/*sunnah* (recommended), *mubah* (neither obligatory nor recommended; neutral) and *makruh* (highly disliked though not forbidden; abstaining is recommended). For practising Muslims, living within the Islamic boundaries in terms of lifestyle and behaviours is generally considered to be an essential part of the religion. A fundamental belief is accountability before God and therefore the avoidance of transgressing Islamic boundaries is emphasised. According to Islam, living within the Islamic boundaries of obligations and avoiding the *haram* is essential to ensure one does not transgress into sin and instead, strengthens one's relationship with God (Gordan, 2009; Nigosian, 2004).

Islam outlines a modest dress code for both males and females. For Muslim women, this includes the *hijab*, which is the covering of a Muslim woman of everything except her hands and face. The *niqab* or *burqa* refers to a veil covering the face. For Muslim men, this includes covering from the navel to the knees. Male dress may include a *kufiah* or 'sunnah hat' (Turner, 2011).

Shariah law (meaning "the way" or "the path") is an important component of Islam that governs much of Muslims' behaviour, in both public and private matters, and includes family and criminal law. Ideally, in Islam there is no separation of religion and state. *Shariah* is implemented in part in many countries such as Iran, Nigeria, Sudan, Pakistan, Afghanistan and Saudi Arabia (Ramadan, 2006). In Iran and Saudi Arabia, *Shariah* law is the primary legal system while in other countries such as Indonesia, Jordan, Bangladesh, Turkey, and India, only certain aspects of *Shariah* family law are incorporated into the states' legal systems (Ramadan, 2006).

Despite common beliefs and practices, Islam is a multi-dimensional religion and religiousness is expressed differently by Muslims around the world (Abu-Raiya, 2015). Islam can mean different things to different people, and some may emphasise certain religious practices and

perspectives more than others. The practice of Islam may also develop throughout an individual's lifetime depending upon their desire to practise the religion and their knowledge, experiences and perspectives. Despite Muslims' diverse cultural, linguistic and historical backgrounds, they share common beliefs and religious practices which provide a faith-based unity. Furthermore, in Western societies such as Australia the mosques, Islamic organisations, centres and schools reveal a prominent religious affiliation, where Muslims from different cultures and backgrounds participate as a community with shared values, beliefs, practices and identity. Islamic principles strongly emphasise group-orientated perspectives, as well as the importance of family, neighbourhood and one's responsibility toward other Muslims. A key part of teachings of the Quran and *hadeeth* is the aim to increase individuals' cooperativeness, selflessness, contribution and participation in the Muslim community, regardless of ethnic, linguistic or social differences (Hedayat-Diba, 2000; Nigosian, 2004).

Islam also promotes a global sense of Muslim brotherhood, which results in a faith identity above other collectivist identities based on ethnic group or geographic locations (Iner & Yucel, 2015). Islamic teachings refer to the notion of *ummah*, which is a faith-based international community of believers that generates a social consciousness among believers and serves to override ethnic and cultural differences (Roy, 2004). A collective Muslim identity is expressed through communal worshipping practices such as the *hajj*, the pilgrimage to Mecca. Other collective community observances include participating in a congregation at Friday prayers or *jumma*, the fasting month of Ramadan, and the twice-yearly *Eid* celebrations. El Azayem and Hedayat-Diba (1994) comment that during the *Hajj*, or pilgrimage, "Muslims from all parts of the world, all walks of life, and all socioeconomic backgrounds, congregate in the holy city of Mecca ... This gathering of about two million people every year is a unique and awesome opportunity for all Muslims to unite in testimony of their faith" (p.46). Such comments highlight the unity of religious worship among Muslims in their ethnic and linguistic diversity.

Muslims in Australia

Muslims have become a more visible presence in Australian society, and in the past two decades the number of Muslims living in Australia has increased significantly due to immigration, conversion and growing birth rates (ABS, 2016). Islam is the second-fastest growing religion in Australia, after Hinduism, and comprises 2.6% of the Australian population (ABS, 2016). Currently, Muslims are the second largest religious group in Australia. Though connected by the common faith of Islam, there is great diversity among Muslims as native customs and traditions modify the practice of Islam and bring variations in their daily lives (Abu Raiya, 2013a; Hassan, 2015). Similar to other Western developed societies, such as the United States and European countries, Muslims in Australia are a highly diverse community from many different cultural, ethnic, linguistic and socioeconomic backgrounds (Hassan, 2015; HREOC, 2004).

Muslims have a long history in Australia. Their presence pre-dates the arrival of the first fleet and Muslim migration continued throughout European settlement. The first known Muslims in Australia were traders from ethnic groups indigenous to the Indonesian Archipelago. Macassan and Bugis traders from Sulawesi visited the coast of northern Australia for hundreds of years prior to the arrival of Europeans to fish for sea cucumber, a marine invertebrate valued for its culinary and medicinal properties. During these voyages, the Macassans left their mark on the people of northern Australia in language, art, economy and even genetics in the descendants of both Macassan and Indigenous Australian ancestors who are now found on both sides of the Arafura and Banda Seas (Ganter, 2008).

Between 1860 and the 1890s a number of Central Asians came to Australia to work as camel drivers. The first arrived in Melbourne in June 1860 when eight Muslims disembarked with the camels for the Burke and Wills expedition. The next arrival was in 1866 when 31 men from Rajasthan and Baluchistan arrived in South Australia to assist Thomas Elder. They settled

near Alice Springs and areas around the Northern Territory, and inter-married with the Indigenous population. These cameleers introduced the first formal establishment of Islam in Australia. The first known mosque was built in Australia in 1882 at Marree in South Australia and the Great Mosque of Adelaide was built in 1890 by the descendants of the camel drivers (Jones & Kenny, 2007).

During the 1870s, Muslim Malay divers were recruited to work on Western Australian and Northern Territory pearling grounds. By 1875, there were 1800 Malay divers working in Western Australia; however, many subsequently returned to their home country. Larger-scale Muslim migration began in 1975 with the migration of Lebanese Muslims, which rapidly increased during the Lebanese Civil War (Batrouney, & Batrouney, 1985). There are also migrants from Somalia scattered throughout Australia who fled their country from the start of the Somali civil war in 1991 (Brasch, 2008).

According to the 2011 census, nearly 62% of those who reported Islam as their religion were born overseas (Hassan, 2015), migrating from a wide range of countries including Lebanon, Turkey, Afghanistan, Bosnia-Herzegovina, Pakistan, India, Indonesia, Iran, Bangladesh, Iran, Fiji, Cyprus, Egypt, Malaysia, Eritrea and Ethiopia. Therefore, a range of languages are spoken by Australian Muslims including Arabic, Turkish, Farsi, Bosnian, Bahasa Indonesia, Bengali, Malay, Dari, Albanian, Hindi, Kurdish and Pashtu. The largest groupings of Muslims in Australia have either Lebanese or Turkish heritage with approximately 30% of Australian-born Muslims claiming Lebanese and 18% Turkish ancestry (ABS, 2016). A common assumption is that Muslims are predominately of Arab or Middle-Eastern background; however, less than 20% of Australian Muslims were born in Middle Eastern or Arab countries. Most Australian Muslims are Sunni but there is also a significant Shi'ite minority (ABS, 2003).

The Australian Muslim population is relatively young; almost 50% are aged 24 years and under (compared to 35% of non-Muslim Australians), while 86% of Australian-born Muslims are aged 24 and under. The majority of Australia's Muslims reside in New South Wales (50%), followed by Victoria (33%), Western Australia (7%), Queensland (5%), South Australia (3%), ACT (1%), with both Northern Territory and Tasmania sharing 0.3% (Hassan, 2015).

Inequalities. National statistics reveal that Australian Muslims experience a range of inequalities compared to the general Australian population (Hassan, 2015). Muslims have higher rates of unemployment and are less likely to be in the labour market (Hassan, 2015). There are significant differences in income between Australian Muslims and the Australian population as a whole; Muslims earn significantly less, both at the household and individual level. Additionally, Australian Muslims are less likely to own or to be purchasing their homes than the average Australian and are more likely to be living in private rental accommodation (Hassan, 2015). Further, research suggests that Muslims in Australia are more likely to experience discrimination when seeking employment, particularly if they are readily identifiable as Muslim, such as by name, dress or physical appearance (Lovat et al., 2013).

Australian Muslim children are more likely to be living in poverty; a quarter of Muslim children live in poverty compared with 14% of all Australian children (Hassan, 2015). In terms of health, older Australian Muslims are significantly more likely to be disabled, or to need assistance with daily activities than Australians in general (Hassan, 2015). Evidence also suggests that Muslims are overrepresented in the prison population. In New South Wales, Muslims represent only 3.2% of the state population, whereas they make up 9.3% of the state prison population (Khoury, 2014). These various inequalities present as risk factors for Australian Muslims' mental health, suggesting that further attention is needed in this area (WHO, 2012).

Conclusion

This chapter provides an overview of Islam and Muslims in Australia. Islam represents one of the main monotheistic religions in the world and for Muslims, Islam provides a complete way of life including beliefs, values and practices which extend into their secular activities. Muslims comprise nearly a quarter of the world's population and reside in countries throughout the world. Muslims throughout the globe are therefore highly heterogeneous in their ethnicity and linguistic background. In Australia, Muslims have a long history, which pre-dates British settlement. In recent decades, the number of Muslims in Australia has increased due to migration, comparatively high birth rates and conversion. Demographic data indicate that Muslims in Australia face a range of inequalities compared to the broader population which pose risks for their mental health. The following chapter provides a review of the literature in relation to the mental health of Muslims. This discussion provides an exploration of the challenges faced by Muslims in terms of discrimination, migration and acculturation. It also considers the potential effects of these issues upon Muslims' mental health. Following this, the available research in regard to Muslims' mental health and the treatment of their mental health difficulties is examined.

Chapter 3

Literature Review: Muslims and Mental Health

Introduction

The previous chapter provided a brief overview of the main tenets of Islam and of Muslims in Australia. This chapter begins by providing an overview of Muslims' mental health and some of the stressors faced by Muslims in Western countries. These include increasing levels of discrimination and racism and adjustment issues related to migration and acculturation. The role of religiosity and religious coping behaviours in dealing with these stressors is explored. Following this, perspectives on mental health among Muslims in majority-Muslim and minority-Muslim countries are examined, along with the ways in which these differ from mainstream conceptualisations of mental illness and its treatment. In addition, help-seeking behaviours, particularly utilisation of and barriers to accessing mental health services, are explored. Finally, the chapter offers a review of research that has examined the provision of religiously and culturally sensitive treatment approaches for Muslims, including religiously-integrated interventions.

Muslims' Mental Health

Issues associated with Muslims and Islam continue to dominate international media and political and public discourse (Aly, 2007; Poynting & Perry, 2007). Meanwhile, very little attention has been directed to the health and wellbeing of Muslims, particularly among those residing in Western countries. Of note, prevalence data of mental illness collected through national censuses (e.g., Australian Bureau of Statistics, Office for National Statistics, US Census Bureau) are not provided based upon ethnic or religious groupings. Therefore, accurate data about rates of mental illness among Muslims living in Western countries such as Australia is lacking, as they are in majority-Muslim countries (Basit & Hamid, 2010).

Rather than population-based studies, a few investigations have been conducted that examine the psychiatric diagnoses of samples of Muslims residing in Western countries. For example, Basit and Hamid (2010) investigated the diagnoses of 875 Muslim Americans, mostly of South Asian ethnicity, but also of Middle Eastern and Bosnian ethnic backgrounds. These participants were seeking treatment at the Hamdard Center for Health and Human Services in Chicago. It was found that, compared to other groups in the United States (e.g., Euro-Americans, Latino American and Southeast Asian Americans), a high proportion of the participants were diagnosed with adjustment disorder (43%). This is likely to have reflected the difficulties associated with the process of adaptation, acculturation and integration when re-settling in a new society. It is important to recognise that this study involved participants who were seeking treatment and so reflects the prevalence of treated conditions, rather than prevalence within the general community. Therefore, these figures do not necessarily represent the clinical picture of Muslims living in America.

Amer and Hovey (2007) investigated the levels of anxiety and depression in a sample of 601 Arab Americans residing in 34 US states. Rather than clinical diagnoses, participants completed self-report measures including the Beck Anxiety Inventory (Beck, Epstein, Brown, Steer & Kazdin, 1988) and the Center for Epidemiologic Studies-Depression Scale (CES_D; Radloff, 1977) to assess their levels of anxiety and depressive symptoms. It was reported that the Arab American participants demonstrated significantly higher levels of depression and anxiety compared to normative samples; a quarter were found to have "moderate" to "severe" levels of anxiety and as many as a half were found to have scores meeting the criteria for depression. While the majority (n = 423; 70.4%) of the participants were Muslim, this study included Christian and other non-Muslim participants. Additionally, only Arab Americans were surveyed. Clearly, given that Muslims residing in Western nations represent a wide

range of ethnic and racial groups, research is required which provides more accurate information regarding their rates of mental illness.

While there is limited prevalence data available, research suggests that Muslims residing in Western countries face a range of risk factors for mental illness. These include socio-economic pressures such as high unemployment (Ali, 2015; EUMC, 2006; Hassan, 2015) along with other social and interpersonal stressors such as exposure to high levels of discrimination and racism, and difficulties associated with migration and acculturation. Indeed, the impact of discrimination on Muslims in Western countries has been identified as a growing concern throughout Western countries (Amer & Bagasra, 2013; Dunn, Klocker & Salabay, 2007; Hassouneh & Kulwicki, 2007; Liepyte & McAloney-Kocaman, 2015; Padela & Heisler, 2010; Rippy & Newman, 2006; WHO, 2012; Zainiddinov, 2016).

Racism and discrimination. Reports show that Muslims in Western societies are subject to high levels of direct and indirect acts of racism, discrimination and social exclusion which can impact their mental health (Allen & Nielsen, 2002; Anderson, 2013; EUMC, 2006). Following the terrorist attacks in the United States on 11 September, the European Monitoring Centre on Racism and Xenophobia (EUMC) implemented a reporting system on anti-Islamic reactions in the 15 EU Member States. Since this time, the annual EUMC reports continue to show that Muslim communities are targets of hostility (Allen & Nielsen, 2002; EUMC, 2006). This includes widespread verbal abuse, harassment and aggression, as well as property damage targeting mosques and Islamic cultural centres.

As in other Western countries, high levels of discrimination have been reported in Australia (Dunn et al., 2015; Dunn, et al., 2004; Dunn et al., 2007; Pederson & Hartley, 2012). For example, the Human Rights and Equal Opportunities Commission (HREOC, 2004) in their report *Isma - Listen* explored the experiences of 1,423 Arab and Muslim

Australians between April and November 2003. The participants reported widespread discrimination and prejudice because of their race or religion. This ranged from offensive remarks to physical violence. Some of the verbal abuse included "terrorist", "dirty Arab", "murderer", "bloody Muslim", "rag head", and "illegal immigrant". The respondents who were most at risk of discrimination were readily identifiable as Arab or Muslim because of their dress, physical appearance or name. Muslim women who wore Islamic dress were particularly afraid of being abused or attacked. They reported restricting their movements and described becoming more isolated since the September 11 attacks. Newly arrived Arab or Muslim migrants reported that experiences of prejudice increased the difficulty of settling into their new country. Overall, the report revealed that experiences of prejudice have a significant impact on Australian Muslims and Arabs, such as heightened feelings of fear, an increased distrust of authority and a growing sense of alienation from the wider community. According to the participants, a lack of knowledge and misinformation about their history, culture and faith were the main causes of prejudice (HREOC, 2004). A number of valuable recommendations were provided including addressing stereotypes and misinformation, and promoting positive public awareness through education. A limitation of this report is that it only examined the experiences of Arab Australians, which included both Muslims and non-Muslims. Furthermore, the research did not provide an understanding of the ways in which the participants coped with their experiences of discrimination.

Another study which explored the experiences of racism and discrimination among Australian Muslims was conducted by the Islamic Women's Welfare Council of Victoria (IWWCV, 2008). This study involved focus groups with 206 Victorian Muslim women. The research examined the extent to which racism was an issue, whether it had increased or decreased in recent years, the impact racism had upon the participants and strategies to reduce racism. The women cited 137 incidents of racism and just under 80% indicated that

they generally felt unsafe and unwelcome in Australia. Almost 90% of the participants reported that they knew of other Muslim women who had experienced racism. The women asserted that racism had a detrimental impact on their sense of wellbeing, sense of belonging, participation in society, and degree of control and agency over their lives. The women noted that they had restricted their independence and freedom of movement due to feeling unsafe in public places and that racism and violence had increased following events of international terrorism and the related coverage. In many cases (80%) the women believed that the broader society no longer wanted them in Australia. An area of exploration lacking from this research was the way in which the women coped and the protective factors which provided a buffer against these stressors.

A recent investigation by Dunn et al. (2015) confirmed the findings of widespread discrimination against Australian Muslims. This study involved 345 face-to-face surveys completed at Sydney mosques, Islamic centres, and Eid festivals, as well as 248 telephone surveys completed with Muslims located throughout Sydney. The survey examined Muslims' sense of belonging and disaffection, beliefs regarding cultural and religious tolerance, and views on relations between Muslims and non-Muslims. The results revealed that the Australian Muslims experienced rates of racism which were dramatically higher than rates experienced by other groups in national data. That is, almost two-thirds of the respondents (57%) had experienced racism in a range of different situations, such as in the workplace or seeking employment, when buying or renting a house, dealing with the police, or accessing health services. In terms of the workplace, 38.8% of the sample reported that they had experienced racism, compared with 10.3% of all Australians. Additionally, the respondents indicated that they had experienced "hate talk" at a level that was three times higher than the rate for all other Australians. Curiously, despite the high levels of reported discrimination, the respondents reported that they had a strong sense of belonging in society and that they felt

comfortable identifying as both Australian and Muslim. Of note, Dunn et al. (2015) found positive associations between religiosity, that is, strength of religious belief, and belonging. Close to 80% of the participants considered that religion was "very important" and over 15% as "important" in their daily lives. It is possible that Muslims' religious beliefs act as a protective factor in coping with stressors such as discrimination.

Research focusing on Muslims in other Western countries similarly suggests a strong sense of belonging despite heightened levels of discrimination. In Britain there has been an increasing frequency of hate attacks, with 14% of those surveyed reporting such attacks in 2010 and this rising to 18% in 2014 (Ameli & Merali, 2015). Despite this, Muslims have been reported to show high levels of loyalty and belonging to the UK (Ali, 2015; Bayrakli & Hafez, 2016). In an article published on November 30, 2014 in *The Independent* titled 'British Muslims Face Worst Job Discrimination of Any Minority Group', Dobson (2014) cited data from the Office of National Statistics in Britain. He reported that they had the lowest chance of being in work or in a managerial role. Meanwhile the 2011 British Census showed that although more than half of the Muslim population were born outside of the UK, 73% considered British as their only identity (Ali, 2015).

Notwithstanding their sense of identity, studies consistently show that frequent experiences of racism can have a detrimental impact on personal wellbeing and mental health (Brondolo et al., 2011; Liu & Suyemoto, 2016; Pascoe, Richman & Cooper, 2009; Priest et al., 2013; WHO, 2012; Williams & Mohammed, 2009). Generally, discrimination has been associated with an increase in the risk of a range of mental health problems such as heightened levels of stress and depression (Anderson, 2013; Noh & Kaspar, 2003). It is likely that negative impacts are also evident for Muslims. For example, Padela and Heisler (2010) investigated the prevalence of perceived abuse and discrimination among Arab Americans and their associated wellbeing. The researchers gathered data from surveys with

1016 Arab Americans in the greater Detroit area, 58% (*n* = 579) of the respondents being Muslim and 42% (*n* = 422) identifying as Christian. As well as asking about their experiences of discrimination participants completed a series of self-report measures including the Kessler Psychological Distress Scale (Kessler, et al., 2002). Of the Muslim participants, 29% reported abuse and discrimination and 19% indicated that they had had a bad experience related to their race, ethnicity or religion. These rates were higher than for the Christian participants. Perceived discrimination and abuse was found to be associated with higher levels of psychological distress, lower levels of happiness and poorer health status. Notwithstanding this study's value, research is needed that includes a broader range of ethnic and racial backgrounds than Arab Muslim Americans in order to be more representative of Muslims who reside in Western societies.

The effects of perceived discrimination were explored by Rippy and Newman (2006) with a sample of 152 Muslim Americans. This research included 84 (56.8%) immigrant Muslims, 21 (13.8%) second generation Muslims and 43 (29.1%) Muslim converts. The participants were administered a discrimination/hate crime questionnaire, Perceived Religious Discrimination Scale (Rippy, 2004), two anxiety scales (Endler Multidimensional Anxiety Scale-State; Endler Multidimensional Anxiety Scale-Trait, Endler, Edwards, & Vitelli, 1991) and a Paranoia Scale (Fenigstein & Vanable, 1992). No correlations were found between perceived discrimination and the measures of state or trait anxiety. However, there was a correlation between perceived exposure to religious discrimination and increased suspicion, vigilance and mistrust among the males. These findings contradict previous research which has shown that perceived discrimination was related to stress and anxiety (Anderson, 2013). The results suggest that there may be important protective factors, such as adaptive coping strategies, which mediate the impact of discrimination. Additionally, the correlation between perceived discrimination and sub-clinical paranoia does not indicate

causation, as it is possible that individuals who were more inclined to be suspicious and hyper-vigilant were also more likely to perceive acts of discrimination against them. This study suggests that in-depth exploration is needed to clarify the impact of discrimination on Muslims and the nature of their coping responses.

Whilst research shows that Muslims in Western countries experience high rates of racism and discrimination (Dunn et al., 2015; HREOC, 2004; IWWCV, 2008) the impact on their mental health remains unclear. Although some research suggests that discrimination against Muslims leads to feelings of isolation and a reduced sense of safety and belonging (HREOC, 2004; IWWCV, 2008), other studies have reported a strong sense of belonging to society despite such experiences (Ameli & Merali, 2004; Ameli & Merali, 2015; Dunn et al., 2015). This suggests a need for further investigations to clarify the protective factors which Muslims can access which serve to moderate the detrimental impact of discrimination.

Migration and acculturation. Typically, a substantial proportion of Muslims who reside in Western countries arrive as immigrants. For example, according to the most recent Australian census, close to 62% of Muslims were born overseas (ABS, 2016). With over half of the Australian Muslim population having migrated to Australia, it is likely that a large proportion have undergone considerable adjustment through the migration process. The process of adapting to a majority or new host culture is commonly known as *acculturation*. According to Berry (2005), *acculturation* refers to the psychological and cultural changes that occur when different groups make contact. Acculturation is a complex process of change on individual, family and cultural levels and involves mutual accommodation between groups, leading to longer-term psychological and socio-cultural adaptations. This process can have positive and negative mental health outcomes. Positive psychological adaptation occurs when the individual develops a clear identity, strong self-esteem and good mental

health (Amer & Hovey, 2007). Resources associated with successful adaptation include problem-solving coping styles, higher education and social support (Berry, 1980).

Alternatively, acculturation can be a highly stressful process and the term *acculturative stress* refers to the unique stressors associated with adjusting to living in a foreign culture or community (Berry & Annis, 1974). *Acculturative stress* arises from intercultural contact which results in tension and is related to negative outcomes. Acculturative stress is associated with identity confusion and anxiety (Albeg, & Castro-Olivo, 2014; Eunha, Hogge, & Salvisberg, 2014). Acculturative stress has been linked to increased psychological distress, such as depression, anxiety and psycho-somatic problems in immigrants and ethnic minority groups (Jibeen & Khalid, 2010; Miller, Kim & Benet-Marinez, 2011; Park & Rubin, 2012; Romero & Roberts, 2003; Sam & Berry, 2006).

Research suggests that migration is often a difficult process which can lead to increased mental health issues (Blair, 2000; Jibeen & Khalid, 2010; Lay, Nordt, & Rössler, 2007; Levecque, Lodewwychx, & Vranken, 2007; Miller, Kim, & Benet-Martinez, 2011; Park & Rubin, 2012; Romero & Roberts, 2003). Migrants who come from countries that are culturally distant, war-torn or politically unstable, exhibit higher rates of psychological morbidity (Knox & Britt, 2002; Stuart, Klimidis, & Minas, 1998). Further, those who migrate as refugees or on temporary protection visas are at a higher risk of experiencing depression, anxiety, post-traumatic stress disorder and emotional distress (Slewa-Younan, Guajardo, Heriseanu, & Hasan 2015; Steel, et al., 2011).

Although research is available regarding the experiences of migrants in general, little is known about the specific concerns of Muslim migrants in Western countries, particularly in Australia (Fozdar, 2011; Khawaja, 2016). This lack of information is puzzling, considering the increased media and political attention directed towards Muslim immigration in recent

decades (e.g., Ata, 2009; Aly, 2007). Nonetheless, the limited research available suggests that Muslim migrants face a range of struggles when resettling in Western societies and these issues are likely to impact on their mental health (Amer & Hovey, 2007; Levecque, Lodewyckx & Bracke, 2009; Sirin & Fine, 2007). Difficulty adjusting to a new society can be compounded for Muslims if they face discrimination (Casimiro, Hancock & Northcote, 2007). Perceived discrimination in addition to acculturative stress is associated with higher levels of psychological distress, depression, anxiety, and psychosomatic symptoms in minority group members (Berry, et al., 2006; Fritz, Chin & DeMarinis, 2008; Motti-Stefanidi, Asendorph, & Masten, 2012). The loss of social supports through migration can hinder adaptation to a new country (Hurtado-de-Mendoza, Gonzales, Serrano & Kaltman, 2014). Muslim migrants often come from cultures which are characterised by interdependent communities such as Arab, African and South Asian countries (Al-Krenawi & Graham, 2000) where individuals are inclined to rely on familial support (Pines & Zaidman, 2003). Interdependent cultures are characterised by cooperation, commitment, shared responsibilities and rewards (Triandis, 2015). For many Muslim migrants, their extended families in their countries of origin have high levels of involvement in assisting with daily housework, child care and social activities (Al-Krenawi & Graham, 2005). Therefore, the absence of such practical and social support can intensify feelings of stress and isolation.

There have been few studies that have specifically investigated the adjustment of Muslim migrants settling in Australia or other Western non-Muslim majority countries. One such study was undertaken by Khawaja (2007) involving 280 Muslim migrants residing in Brisbane. The participants completed a series of self-report measures including a social support scale, coping measure and a measure of psychological distress. It was found that participants who were single (n = 107) were more distressed than those who were married (n = 171), and individuals with a temporary visa (n = 75) were more distressed than those who

had obtained permanent residency (n = 72). Some of the other factors that predicted psychological distress were perceived difficulties with English, a lack of social support, separation from family, and a tendency to use avoidant coping styles. Khawaja (2007) concluded that participants experienced a sense of marginalisation from the mainstream population, which was related to increased psychological distress. The investigator recommended that mental health practitioners tailor their interventions for Muslim migrants to enhance coping skills which integrate their cultural and religious beliefs with the requirements of living in a Western society. This research identifies factors which are relevant for the coping outcomes of Muslims in migrating to Australia. However, the majority of the participants were well educated, proficient in English, employed, and the average length of stay in Australia was a decade. Therefore, these findings may not be representative of a more diverse group of migrants, particularly those in the initial stages of resettlement in Australia. A further limitation is that participants were not given an opportunity to explore their experiences adjusting to life in Australia.

An investigation which focused on Australian Muslim immigrants in their initial stages of resettlement was performed by Casimiro et al. (2007). This study examined the resettlement issues of Muslim refugee women in Perth during their first five years of arrival. A qualitative approach was used that involved focus groups as well as semi-structured interviews with 80 Muslim refugee women (35 Iraqi, 34 Sudanese and 11 Afghan). It was found that the participants had a number of difficulties in their resettlement such as poor English language competency, difficulties obtaining employment and difficulties securing accommodation. Many of the women experienced racism in the process of attaining work, or at work. The women stated that their isolation, status and gender roles had become worse as a result of settling in Australia. However, the biggest concern for the women was their increasing sense of fear and insecurity. The lack of personal safety and security was specific

to their religious identity as they had encountered threatening and abusive language about being Muslim. The women repeatedly referred to ignorance about Islam and negative attitudes towards Muslims in the broader Australian community. The participants considered that the social and political climate played a major role in attitudes towards them in the Australian community, particularly in relation to international terror attacks and the media portrayal of Muslims. This research focused on the difficulties the women faced throughout the resettlement process, however, it did not explore the factors which assisted the women to cope with the stressors of adaptation. In this regard, it would be useful to gain an understanding of the coping responses of Muslim immigrants' pre-and post-immigration through longitudinal studies. Developing an understanding of helpful coping responses for Muslim immigrants is needed to inform treatment approaches and interventions that are relevant for their needs. This may also assist in identifying the types of supports and treatment interventions which are needed at different stages of re-settlement.

In summary, Muslims residing in Western nations such as Australia are faced with a range of vulnerabilities and stressors. In addition to heightened experiences of discrimination and stressors associated with immigration, Muslims are subject to higher rates of unemployment, poverty and disability (Ali, 2015, Dunn et al., 2015; Hassan, 2015; EUMC, 2006). In circumstances where individuals are exposed to a multitude of inequalities and stressors, the risk of developing a mental illness is heightened significantly (WHO, 2012).

Protective Factors for Muslims' Mental Health

Although there is a lack of data regarding the prevalence of mental illness among Australian Muslims, some studies have investigated indices of wellbeing. One investigation by Akbarzadeh et al. (2009) surveyed 290 Australian Muslims regarding their hopes, concerns and worries. Interestingly, Australian Muslims scored higher than Australians

generally in areas such as overall personal wellbeing, standards of living, personal relationships, and community connectedness. The exception was lower feelings of safety and future security compared to other Australians. The investigators observed that the lower scores on safety and future security were a result of the negative focus on Muslims, particularly in politics and the media. Curiously, no explanation was offered for the Muslims' higher levels of personal wellbeing and satisfaction. It could be that their religion provided a moderating effect for the risk factors they faced. Clearly, further research is warranted to determine the factors which contribute to the personal wellbeing of Muslims in Western countries.

In a more recent investigation, Woodlock (2012) surveyed the personal wellbeing of 509 Australian Muslims using the Australian Unity Wellbeing Index (Cummins, 2007). It was found that the level of wellbeing was comparable with the general Australian population. Even so, as with previous research (i.e., Akbarzadeh, et al., 2009), scores for safety and future security were at substantially lower levels of satisfaction compared to the general population. Such perceptions are concerning and suggest that there are widespread fears amongst Australian Muslims which may represent a risk for their mental health.

It should be noted that wellbeing is assessed using subjective measures and wellbeing scores do not necessarily reflect Muslims' mental health. Nevertheless, considering that studies suggest good subjective wellbeing among Australian Muslims, there are likely to be protective factors which mitigate against the range of risk factors that they face. Given that Muslims tend to report strong religious affiliation, it appears that religion may play an important role in contributing to wellbeing (Dunn et al., 2015).

The role of religion. The role of religious beliefs in mental health has been a growing area of research over the last two decades (Hummer, Rogers, Nam & Ellison, 1999;

Lewis, Breslin & Dein, 2008; Loewenthal, 2007; Maltby, Lewis & Day, 1999; Pargament, 1997; Plante, & Sharma, 2001; Snider & McPhedran, 2013). Studies have revealed positive associations between religious beliefs and practices, and psychological wellbeing (Gartner, Larson & Allen, 1991; Hood, Hill, & Spilka, 2009; Paloutzian & Park, 2005; Pargament & Abu-Raiya, 2007) and that religious beliefs and practices can act as a buffer for individuals against stressful life experiences. That is, religion can provide helpful coping responses which enhance resiliency when faced with stressful circumstances, such as seeking help through prayer or finding meaning in challenges and stressful life events (Gall & Guirguis-Younger, 2013; Hamilton, Moore, Johnson & Koenig, 2013; Koeing, George & Peterson, 1998; Pargament et al., 1998; Pargament et al., 1990). Religion also offers a range of practices for the purpose of spiritual connection to a higher power, such as engaging in prayer, reading sacred writings, and meditating (Pargement, 2007). A belief in a higher power can help to overcome feelings of helplessness, providing a framework for understanding difficult circumstances and a sense of meaning or purpose (Loewenthal, 2007). Individuals may call upon God to provide them with strength to cope with difficulties (Bänziger, van Uden & Janssen, 2008; Bennett & Elliott, 2013). Additionally, the network of a faith-based community may provide assistance and support when one is facing challenging or stressful circumstances (Shifrin, 1998).

Muslims in Western countries tend to report high levels of religiosity (Dunn et al., 2015; Woodlock, 2011). Therefore, it is likely that, similar to other religious groups, religion plays an important role for their wellbeing and mental health. The positive association between religiosity and mental health and wellbeing is evident in studies of Muslims in both majority-Muslim and minority-Muslim countries. Abdel-Khalek (2010) investigated the associations between quality of life, subjective wellbeing and religiosity among a sample of 224 university undergraduates in Kuwait. The World Health Organisation Quality of Life

Scale-Brief (WHOQOL, 1994) was used, as well as self-rating scales of physical health, mental health, happiness, satisfaction with life, religiosity, and strength of religious beliefs. Participants who scored higher on religiosity and religious belief tended to report a higher quality of life and enhanced subjective wellbeing. However, a limitation of this study is that the measure used to assess religiosity was a single item. A single-item measure (e.g., "What is the strength of your religious belief?") does not account for diverse interpretations which individuals assign to the notion of being religious. Additionally, the reliability of single-item measures tends to be uncertain (Hoeppmer, Kelly, Urbanoski & Slaymaker, 2011).

In a study which used a more extensive measure of religiosity (i.e., The Religious Attitude Questionnaire; Khodayarifard, Yekta, & Bonnab, 2000), Sahraian, Gholami, Javadpour and Omidvar (2013) examined the relationship between happiness and religiosity with 271 undergraduate medical Muslim students in Iran. It was found that higher scores on religious belief were associated with greater reported happiness. However, as this study was correlational, the direction of the relationship between religiosity and happiness is unknown. It could be that religiosity leads to higher feelings of happiness, or people who are happier tend to be more religious. If religiosity leads to happiness, greater understanding of how this is achieved is required. In order to gain this understanding, research methods such as qualitative approaches would need to allow Muslims to explore the ways in which they perceive that religiosity contributes to their positive feelings.

Studies in Western societies have also revealed associations between religiosity and wellbeing. Alflakseir (2012) investigated the relationship between personal meaning, psychological wellbeing, spirituality, and religiosity among 60 Muslim university students in England. The participants were administered the Life Attitude Profile-Revised (Reker, 1999), the Sources of Meaning Profile-Revised scale (Reker, 1996), the Psychological Well-Being Scale (Ryff, 1989) and the Strength of Spiritual Belief Scale (King, Speck, & Thomas,

2001). The results showed that those who practised Islam were more likely to perceive their life to be meaningful. Taking part in religious activities and engaging in personal relationships with family and friends were reported to be the most important sources of meaning for the participants. Positive associations were identified between personal meaning and psychological wellbeing, spirituality and religiosity. However, the measures used did not illuminate the specific features of religion which contributed to the participants' wellbeing. It would be useful for research to explore the specific ways in which Muslims consider their religiosity is of assistance.

Jasperse, Ward, and Jose (2012) explored the relationship between perceived discrimination, visible Muslim identity and predictors of psychological wellbeing with 153 Muslim women of diverse ethnic backgrounds in New Zealand. The participants were administered a range of scales measuring Muslim identity, perceived religious discrimination, psychological wellbeing and psychological symptoms. Greater visibility (i.e., the wearing of a hijab) was associated with greater perceived discrimination. Strong religious affiliation was found to moderate the relationship between perceived discrimination and wellbeing. That is, engaging in Islamic practices appeared to buffer the negative impact of discrimination for the participants. It would be useful for further studies to explore the perspectives and experiences of Muslims to gain an understanding of the specific ways in which religious affiliation assists their coping in the face of external stressors such as discrimination.

In a recent study, Hodge, Zidan, Husain and Hong (2015) investigated the role of discrimination and spirituality as risk and protective factors for depression among 269 American Muslims of varied ethnic backgrounds. Using a range of self-report measures, it was found that participants who had experienced being called offensive names were more likely to report clinically significant levels of depressive symptoms. Regardless of the type

of discrimination experienced, performing daily prayers was found to be protective against depression.

Although these studies (Abdel-Khalek, 2010; Alflakseir, 2012; Hodge et al., 2015; Jasperse et al., 2012; Sahraian et al., 2013) draw attention to the positive role of religiosity among Muslims who reside in both majority-Muslim and Western societies, they do not provide an understanding of the specific ways in which Islam can support Muslims' mental health. There is a lack of research which explores differences in the role of religiosity in mental health between Muslims who reside in majority-Muslim societies and those who reside in minority-Muslim societies._There is a need for qualitative research which provides Muslim participants with a voice to describe the ways in which their faith and religious practices contribute to their mental health and wellbeing.

Religious coping. Coping has been defined as a process which involves a range of thoughts, feelings, and behaviours that a person uses to manage internal and external stressors (Folkman & Moskowitz, 2004; Lazarus & Folkman, 1984). Coping behaviours can be characterised as functional or dysfunctional depending upon the types of behaviours and thoughts (Parker & Endler, 1992). Religious coping extends these behaviours to include beliefs, practices and perspectives which are drawn from that which is considered sacred, such as religion and spirituality (Abu-Raiya & Pargament, 2015; Pargament, 1997). The "sacred" can be considered as a higher power, such as God or transcendent reality, or other aspects of life that are deemed to be connected to the sacred or have sacred qualities (Pargament & Mahoney, 2005). Therefore, what is considered to be sacred can include behaviours (e.g., prayer, meditation), psychological perspectives (e.g., finding meaning), social aspects (e.g., community), time (e.g., the Sabbath), people (e.g., religious leaders), places (e.g., temples or churches) or objects (e.g., prayer beads).

Pargament's (1997) theory of religious coping helps to explain the role of religion in responding to stressful life events. This theory asserts that events can impact people in various domains of their lives including physical, psychological, social, and spiritual. Pargament (1997) argues that if stressors or situations are perceived as challenging the individual's framework of sacredness, then they are likely to apply coping strategies that hold, or transform, their most significant values. Therefore, sacred-related ways of understanding and dealing with difficult life situations may be highly beneficial for individuals for whom religion and spirituality is a priority.

Distinctions have been made between positive and negative religious coping methods (Pargament, Koenig, & Perez, 2000). Positive religious coping refers to a secure connection with a higher power, and turning to a higher power, such as God, for spiritual support, connection, forgiveness, and guidance. Positive religious coping methods assume that God is a trusted, benevolent force in one's life and include a perspective that there is greater meaning or purpose in one's difficulties. There may also be a sense of spiritual connectedness with others (Pargement et al., 1998; Pargament et al., 2000). Positive religious coping methods have been associated with better psychosocial outcomes, such as lower reports of depression and anxiety (Maltby & Day, 2002). In contrast, negative religious coping is characterised by an insecure connection with God and may include a sense of abandonment by God. Stressful life events are characterised as punishments from God. Negative religious coping is associated with greater emotional distress, depression, posttraumatic stress, lower life satisfaction and poorer physical health (Ano & Vasconcelles, 2005; Fitchett, Rybarczyk & DeMarco, 1999; McConnell, Pargament, Ellison, & Flannelly, 2006).

Studies which investigate religious coping methods have highlighted the adaptive and protective function for individuals who employ positive religious coping methods for a range

of difficulties and stressors (e.g., Warren, Van Eck, Townley & Kloos & Piedmont, 2015). These benefits are evident among Muslim populations in both majority-Muslim and minority-Muslim societies. For example, Gardner, Krägeloh and Henning (2014) explored the associations between levels of spirituality, religiosity, perceived stress, quality of life and positive and negative religious coping among 114 Muslim university students in New Zealand. The use of positive religious coping by the participants was found to be related to higher quality of life and lower levels of stress.

The benefits of positive coping strategies have been reported in Muslim populations who have experienced significant trauma. For example, Aflakseir and Coleman (2009) investigated the impact of religious coping using the Religious Coping Scale (Pargament et al., 2000) in a sample of 78 Iranian veterans with physical disabilities as a result of the Iran-Iraq war. It was found that when physical function, social support, and personal meaning were controlled, religious coping had a significant positive relationship with indicators of mental health. Further, in coping with physical disability and trauma, the participants tended to use positive religious coping strategies, which included reading the Quran, praying, and viewing their difficulties as a means to strengthen their relationship with God. Overall, the participants used positive religious coping strategies more frequently than negative strategies. Major limitations with the study, however, are that the specific ways in which the participants employed religious practices as part of their coping responses and the effectiveness of their religious coping responses were not investigated.

In a study conducted in the US, Ai, Peterson and Huang (2003) investigated the religiosity, war-related trauma, religious-spiritual coping, optimism and hope of 138 Muslim refugees from Kosovo and Bosnia. The participants were found to employ positive religious coping strategies more regularly than negative coping methods. It was also found that positive religious coping was associated with optimism. Again, this suggests that religion

can have an adaptive role for Muslims. Whilst this research is valuable, further exploration is needed to understand the meaning of positive religious coping responses for Muslims. Understanding the specific ways in which Muslims utilise religious coping may inform the development of treatment approaches and assist practitioners working with Muslim clients.

In a recent investigation, Adam and Ward (2016) investigated acculturative stress and religious coping as predictors of wellbeing in 167 Muslims immigrants and their descendants in New Zealand. The participants were administered a measure of stressful life events, a 24-item Muslim Religious Coping Scale, a measure of life satisfaction and a scale of anxiety, depression and somatic symptomatology. As expected, acculturative stress was found to predict a lower level of life satisfaction and more psychological symptoms. Muslim Religious Coping independently predicted greater life satisfaction, however, was not found to produce a significant influence on psychological symptoms. Furthermore, the study showed that no dimension of Muslim Religious Coping (i.e., cognitive, behavioural or social) moderated the relationship between acculturative stress and psychological symptoms. Unlike participants in previous studies (e.g., Aflakseir & Coleman, 2009; Ai et al., 2009), a large proportion of participants in this investigation were unlikely to have had distinct trauma experiences and so they might have been less likely to have relied on religious coping responses.

A search of the literature identified one study that has focused on the coping of Australian Muslims (Khawaja, 2008). It involved 319 Muslim migrants who were administered the COPE scale (Carver, Scheier, & Weintraub, 1989), the Coping Inventory for Stressful Situations (Endler & Parker, 1995) and the Hopkins Symptom Checklist (Degogatis Lipman, Rickels, Uhlenhuth & Covi, 1974). The participants were found to use coping responses which were similar to those employed by the broader Australian society. That is, they used Active Coping, a more individualistic coping style that involves active problem

solving, planning, and self-reliance. Notably, the participants also retained coping behaviours based upon their religious beliefs and practices. These findings suggest the merging of different influences through the acculturation process in Australian Muslims' coping responses. However, a key limitation of the study is that it does not provide insights regarding the way in which the participants drew upon different coping styles to support their mental health. Furthermore, it did not examine the way coping responses changed over time. Whilst the use of self-report scales is useful to gain a picture of broad categories of behaviours, they do not shed light on individual experiences of coping through the acculturation process.

The evidence presented shows that positive religious coping strategies and religiosity are associated with indicators of wellbeing for Muslims in both majority-Muslim and minority-Muslim countries, such as higher levels of quality of life, satisfaction in life and optimism, as well as lower anxiety, pessimism, trauma symptoms and stress (Abdel-Khalek, 2010; Abdel-Khalek & Naceur; 2007; Abu-Raiya, 2013b; Alflakseir, 2012; Aflakseir & Coleman, 2009; Ai et al., 2003; Gardner et al., 2014; Sahraian, et al., 2013). Whilst such research is valuable, these studies do not explore the meaning of religious coping and the lived experiences of Muslims utilising religious beliefs and practices in response to their stressors. Furthermore, the available literature does not explore whether there are differences in the use of religious coping practices between Muslims living in majority-Muslim societies and those living in minority-Muslim societies.

Muslims' Perceptions of Mental Health and Illness

In order to effectively address the mental health needs of Muslims, it is necessary to understand the issues which are pertinent to their treatment. The evident role of religiosity and religious coping for Muslims in their mental health suggests that research is needed to

gain insight into their perspectives of mental health and illness. Given that Islam is important for Muslims' wellbeing and management of psychological distress, religious beliefs are also likely to be involved in their conceptualisation of mental health problems.

Although research is scarce, some studies have investigated the role of religious beliefs in Muslims' conceptualisation of mental illness in both majority-Muslim and Western societies. For example, Al-Adawi, Al-Sinawi, Al-Adawi, Jeyaseelan and Murthi (2002) examined the conceptions of mental illness in Oman. The study included 173 medical students, 64 relatives of psychiatric patients and 231 members of the public. These participants were administered the Attitudes Towards Mental Illness Questionnaire (Weller & Grunes, 1988) which was translated into Arabic and included modified items to reflect the cultural views of Omani society. The majority of medical students and the general public expressed the belief that spirits cause mental illness. The study found that contact with individuals with a mental illness did not affect their attitudes, as relatives of individuals with a mental illness expressed negative perceptions of people with mental illness. Although most of the participants preferred that psychiatric facilities are located away from the community, most agreed that mental illness is treatable and that people with mental illness should be integrated in the community. Whilst the study provides an indication of the conceptions of mental illness among people in Oman, as the questionnaire was modified and therefore the validity is not known. Further, the questionnaire was limited to just 16 items with forced-choice response options. Attitudes toward mental illness are likely to be complex and multi-faceted and such measures do not provide participants with the opportunity to elaborate upon their views and give a more nuanced description of their perspectives.

Eltaiba and Harries (2015) investigated the way in which 20 Muslim individuals in Jordan perceived the causes of their mental health problems, their coping strategies and their experiences of recovery. Semi-structured interviews were conducted with 10 male and 10

female participants who had suffered from mental illnesses such as depression, anxiety, obsessive compulsive disorder and panic attacks. A benefit of this study was that the semi-structured interview approach allowed the participants to explore the issues which were most relevant for them. A main finding was that religion played a positive and central role for the participants in their recovery from mental illness. All of the participants considered that the meaning of their life and their relationship with God was strengthened as they tried to understand their mental illness and find solutions to their difficulties. The participants framed their mental illness as God's will and referred to Quranic verses or prophetic traditions which influenced the way in which they understood their illness. This research is one of the few studies which provides a qualitative exploration of Muslims' views of mental illness. However, as all the participants were being treated for diagnosed mental illnesses, it is not clear whether these views are reflective of the broader population of Jordanian Muslims.

A wide-ranging study of views toward healing was conducted by Padela, Killawi, Forman, DeMonner and Heisler (2012). The investigation involved 13 focus groups consisting of a total of 102 American Muslims, representing a range of ethnicities. The participants perceived their overall health as having spiritual, physical and mental components. They described a God-focused view of healing where God was considered to be central in the healing process and help from God for health could be sought through supplication (*du'a*) and reciting the Quran. God was also viewed as providing help indirectly through the actions of human agents such as health care providers, family members, community members and religious figures. Ultimately, health was seen to be in the hands of God. All of the focus groups identified a crucial role for the local imam in healing for their community, such as delivering health care messages, providing spiritual support and healing, counselling, and educating non-Muslim health care staff members. Family was also

identified in healing, providing physical care, emotional and spiritual support, and mediating interactions with health care providers. Whilst this study provided a picture of Muslims' perspectives of healing and primary agents in the healing process for Muslims living in a Western society, the research explored views of healing generally and did not have a specific focus on mental health. Therefore, it is not known whether the outcomes would be similar for mental health problems, or whether other considerations in the healing process would emerge.

Another qualitative study investigated Muslims' views of mental illness living in a Western society (Weatherhead & Daiches, 2010). Rather than focusing on a sample of Muslims from one cultural group, this research involved 14 Muslims from a range of different cultural backgrounds living in the United Kingdom with most (n = 10) being first generation migrants. Semi-structured interviews were used to explore the participants' perspectives of mental illness and its treatment. Interestingly, the respondents expressed perspectives which incorporated both religious and secular views of mental illness and treatment. Examples of religious perspectives included that their illness was a punishment or a test from God, or caused by supernatural elements such as witchcraft or *jinn*. Secular perspectives included that mental illness resulted from stressful life events or drug taking. Participants' views on problem management included religious and secular approaches, such as prayer and seeking help from religious leaders, in addition to seeking help from friends, family and mental health professionals. The participants reported that religion was useful in managing their problems and they noted the benefits from turning to Islam during difficult times. These findings provide a picture of Muslims in a Western society merging two distinct frameworks, religious and secular models, in order to understand and treat mental illness. This suggests that Muslims in Western societies may be influenced by both their religious beliefs and the mental health perspectives of the society in which they reside. Yet, this study

did not provide information regarding the level of religiosity of the participants, which would have been useful to determine whether there were differences in their perspectives based upon the strength of their religious affiliations. Furthermore, it is not known whether the perspectives are similar for Muslims in majority-Muslim societies. It would be useful to explore whether the views of Muslims are subject to change due to the influences of the environment in which they reside.

Research about Muslims living in Western countries (e.g., Aloud & Rathur, 2009; Amer & Hovey, 2007; Padela & Heisler, 2010; Youssef & Deane, 2006) has tended to focus on groups of Muslims who reside within a particular area or from one ethnic or racial group. Research is needed which includes participants who are representative of the diversity of Muslims. Such research could be extended by exploring the perceptions and experiences of Muslims who reside in Western societies with those in majority-Muslim countries. As a large proportion of Muslims who reside in the West have migrated from majority-Muslim countries (Ali, 2015; Hackett, 2017; Hassan, 2015) it is important to understand the process of acculturation with respect to the role of religion and mental health. To date, no published study compares Muslims residing in Western societies with those who reside in majority-Muslim countries in terms of their views of mental health. This would be useful to distinguish the influence of culture from religion on perspectives of mental health. Qualitative methods would be particularly useful as they can provide flexibility for participants in order to allow a depth of exploration to illuminate the complexities of their perspectives and experiences.

Muslims' Help-Seeking Pathways and Barriers to Treatment

In addition to understanding the ways in which Muslims conceptualise mental illness, research is needed to clarify Muslims' utilisation of mental health services and the main

barriers to seeking help. Considering that Muslims residing in Western societies face a range of stressors, utilisation of mental health services is a relevant area to be explored. This may help to clarify the factors which facilitate access to treatment services.

Barriers to accessing services. The available research indicates that there are a range of attitudinal barriers for Muslims in terms of accessing mental health services. The research highlights a range of attitudinal barriers for Muslims residing in both majority-Muslim and minority-Muslim societies. Al-Darmaki (2003) examined the attitudes of 350 Emirati Arab undergraduate students by administering the measure of Attitudes Toward Seeking Professional Help (Fischer & Turner, 1970). The students identified a number of barriers to help-seeking including a perception of stigma, fear of treatment, and reluctance to self-disclose. An important limitation with this study was that the participants were unable to elaborate on their views of these barriers and whether they may be open to change.

Research involving Muslims living in Western countries similarly suggests attitudinal barriers to accessing professional mental health treatment. The investigation by Weatherhead and Daiches (2010) (described in the preceding section) identified several issues relating to Muslims' help-seeking in the United Kingdom. Participants expressed positive perceptions of professional treatment, however, they also described a fear of being stigmatised in their communities, fear of stereotyping by service providers, and concerns given previous negative experiences with services. Another barrier included the belief that accessing professional help is an indication that they had not been able to manage their problems through their religion. Participants emphasised the importance of practitioners providing religiously and culturally sensitive treatment and considered that showing respect for their religion was a key part of developing a trusting therapeutic relationship. Although this study provides valuable findings, it offers limited exploration of the meaning of these barriers for participants. This

includes the way in which the barriers were developed or reinforced, the extent that they prevented access to mental health services and ways that they could be challenged.

There has been some research which investigates the attitudes of Muslims residing in the United States towards accessing mental health services. For example, Khan (2006) investigated the attitudes of Muslims living in Ohio toward help-seeking, as well as the need for and use of professional counselling services. A total of 459 Muslim participants completed the Attitudes Toward Seeking Professional Psychological Help Scale (Fischer & Turner, 1970). Similar to other investigations (e.g., Weatherhead & Daiches, 2010), Khan (2006) found that the participants reported a need for mental health assistance. Despite the majority holding positive attitudes towards counselling, there was a lack of usage of mental health services. The majority of the respondents reported turning to alternative sources of help such as prayer, the Quran and family. Unfortunately, the investigator did not provide an explanation for the limited uptake of services.

In another study conducted in the United States, Aloud and Rathur (2009) investigated attitudes towards accessing mental health services among 279 Arab Muslims. The participants completed the Attitudes Toward Seeking Professional Psychological Help Scale (Fischer & Turner, 1970) and two instruments developed for the research, the Cultural Beliefs About Mental Health Problems and Knowledge about and Familiarity with Formal Mental Health Services. Based upon their findings, Aloud and Rathur (2009) developed a model of help-seeking behaviours among Arab Muslims, called the Help-Seeking Pathways of Arab Muslims (HSPAM). According to the HSPAM, Arab Muslims tend to go through three stages when experiencing mental health problems and encounter a range of personal, professional, and organisational obstacles when progressing through these stages. In the first stage, becoming aware and recognising a problem, the model proposes that Arab Muslims may be influenced by cultural and religious conceptions of mental illness, individual

knowledge of mental illness and its treatment, and Arab coping styles. In the second stage, deciding to seek help, the model indicates that social stigma associated with mental health problems, negative attitudes towards service providers, a lack of confidence in formal services and their providers, and the use of other supports such as family and community networks may impede access to services. In the third stage, service selection, Arab Muslims' help-seeking behaviours may be influenced by the preference for religious healing, a lack of awareness of available services, acculturation influences and economic and institutional barriers. Whilst Aloud and Rathur's (2009) research provides a useful framework to understand the help-seeking patterns amongst a group of Arab Muslims, it is important to explore in some detail Muslims' personal experiences of each of these stages. For example, it would be beneficial to gain a deeper understanding of the participants' negative attitudes towards services providers, particularly in relation to their lack of confidence in treatment professionals. Gaining an understanding of such barriers to accessing services, how they developed, and the factors that maintain them may assist in determining ways that these issues can be effectively addressed within Muslim communities. Furthermore, it would be valuable to explore whether informal and religious assistance may be incorporated with professional treatment to provide a more relevant approach for Muslim clients.

Aloud and Rathur's (2009) HSPAM appears to be the only framework that describes the factors which inhibit American Arab Muslims' accessing mental health services. The main limitation of the model is that it is based upon research involving one ethnic group of Muslims. As such, it is not known whether this model is applicable to Muslims from other cultural and ethnic backgrounds. Further research is required in order to determine whether this model is applicable to Muslims from different ethnicities and societies, such as Muslims in Australia, or Muslims who reside in majority-Muslim societies.

One of the few studies of help-seeking behaviours which includes Australian Muslims was performed by Youssef and Deane (2006). The researchers conducted semi-structured interviews with 35 Arabic-speaking participants (including both Muslims and Christians) exploring their perceptions of mental illness in the Arab community and their preferred forms of support and treatment. In regards to perceptions of mental illness, 86% of the participants stated that in their community people often believe that mental illness is caused by satanic powers. In terms of help-seeking, the participants identified religious leaders as a first point of contact for mental health problems. As far as treatment was concerned, the majority of participants (91%) considered that their community would usually turn to spiritual healing, or enrich their faith through religious practices. Participants were concerned that due to a lack of knowledge about mental illness, conditions such as depression are often not recognised and therefore remain under-diagnosed. In terms of accessing mental health services, a number of barriers were identified. Shame and stigma were considered to be the main obstacles to accessing professional help. Additionally, a lack of trust in service providers and concern about confidentiality were identified as important issues. The study also found that there was a lack of knowledge about available services. A key limitation of this study is that no distinctions were made between the perspectives of the Muslim and Christian participants. Furthermore, there are many Australian Muslims who are non-Arabic speakers, and therefore research is required to determine the factors that influence help-seeking for other cultural and linguistic groups.

It appears that religious leaders play a primary role in Muslim communities as a source of help. For example, Osman, Milstein and Mazruk (2005) investigated the role of 62 imams in the United States in meeting the counselling needs of their communities using a 79-item questionnaire (developed by the researchers). The imams reported a substantial increase in requests for counselling since September 11, 2001, particularly from Arab Americans.

Few of the imams had received formal counselling training, yet they were regularly providing assistance to their congregations beyond religious and spiritual concerns, including mental health and social problems. Although the imams appeared to play an important role, the authors raised concerns regarding their expertise and effectiveness in meeting the needs of their community. Unfortunately, this research did not explore the views and experiences of the Muslims who had received assistance from the imams. This would be useful in order to understand the reasons that Muslims seek their assistance and whether they perceive their assistance to be effective.

Other studies in the United States have similarly highlighted the position of imams for the Muslim community in responding to personal issues. Abu-Ras, Gheith and Cournos (2008) investigated the role of 22 imams from mosques in New York City regarding mental health promotion. The imams completed a survey specifically designed for the research to elicit information regarding the mental health needs of the Muslim community since September 11 and their role in addressing these needs. The study found that the imam was usually the first and only contact for the worshippers' personal and mental health problems, and yet most imams were not knowledgeable about mental health resources in the community. The research identified a range of concerns regarding the reliance upon local imams for help. Most of the imams were not born in the US, had difficulty speaking English and almost none had any formal training in pastoral crisis interventions or Western psychotherapy methods. The imams reported difficulty in differentiating between the symptoms of various mental illnesses and a lack of familiarity with treatment services. Due to this lack of training, the imams were unable to make appropriate referrals to mental health services. Nonetheless, the majority of the imams expressed enthusiasm about learning Western methods of treatment and considered that combining Islamic traditions with modern psychotherapy and medication was the most effective way to treat Muslims experiencing

mental health problems. Most imams were also of the view that they would be able to assist their community more effectively if they had training in pastoral crisis counselling. This research highlights a prominent role for imams in providing support for Muslims, however, a lack of training meant that they were likely to be limited in their effectiveness. Given the openness of the imams to combining professional approaches with Islamic traditions, the findings suggest that with appropriate training, religious leaders may be a valuable resource within the Muslim community to encourage utilisation of professional mental health services.

A tendency to favour religious leaders and spiritual treatments as opposed to professional mental health services is also evident in majority-Muslim societies. Al-Krenawi, Graham and Kandah (2000) investigated the utilisation of mental health services in Jordan. A revised Hopkins Symptom Checklist (Derogatis, Lipman, Rickerts, Uhlenhuth, & Cori, 1974) translated into Arabic was distributed to 87 male and female non-psychotic Muslim outpatients. The majority of the respondents reported a preference towards traditional healing over biomedical services. The investigators reported that this was because the traditional and religious leaders lived in the respondents' community, shared their worldview, made no labelling diagnoses and used brief and spiritual treatments. Similar findings were reported by Al-Krenawi (2002) who investigated the utilisation of mental health services among Jewish and Muslim Arab communities in Israel through the analysis of national hospitalisation records. This study reported an under-utilisation of services among Arab Muslim individuals. Al-Krenawi (2002) proposed that Muslim Arab patients in Israel tend to seek help in a hierarchical manner, first turning to their family and friends, then to a general practitioner, followed by a religious healer, and then if the problems persisted, they followed the general practitioner's referral to professional mental health treatment. This suggests a preference among Muslims for informal sources of support, such as family, friends, and traditional healing. However, the research did not investigate whether Muslims perceive that

these alternative forms of help are effective in managing mental health problems, or whether they reinforce their reluctance to access services thereby resulting in mental health problems remaining untreated.

Although research identifies the significant position of religious leaders for Muslims (e.g., Abu-Ras et al., 2008; Osman, et al., 2005), investigation is needed to further understand their role in meeting Muslims' mental health needs. The effectiveness of religious leaders in assisting Muslims with mental health problems is not known, and is an important area for study, particularly from the perspectives of the Muslims who seek their help.

As indicated earlier, Muslims can be reluctant to utilise mental health services due to concern regarding societal and community stigma associated with mental illness. In many cultures, there is a strong stigma associated with mental health problems and the treatment of mental illness (Cheon, & Chiao, 2012; Mellor, Carne, Shen, McCabe & Wang, 2013; Tzouvara & Papadopoulos, 2014). Particularly in interdependent societies, stigma is not only attached to an individual, it can be attached to the family (Dalky, 2012). In many Muslim societies, there is profound social stigma associated with accessing mental health treatment, particularly as Islam is seen as the source of healing and strength (Ciftci, Jones & Corrigan, 2013). The belief that mental health problems can be attributed to spiritual and supernatural problems is strongly ingrained among Muslims (Farooqi, 2006; Keshavarzi & Haque, 2013). Research also suggests that there is stigma attached to mental health services among Muslims who reside in Western countries such as the United States, and as such mental illness and mental health services may be viewed negatively (Aloud & Rathur, 2009; Kira et al., 2014). The stigma attached to psychological problems might explain why many Muslims prefer to seek help within their family or from religious leaders. This is likely to be more socially acceptable and protects the family from negative public opinion (Al-Krenawi & Graham, 2000; Aloud & Rathur, 2009).

The current literature (Abu-Ras, et al., 2008; Al-Krenawi, 2002; Al-Krenawi & Graham, 2000; Aloud & Rathur, 2009; Ciftci, et al., 2013; Farooqi, 2006; Keshavarzi & Haque, 2013; Kira et al., 2014; Weatherhead & Daiches, 2010) shows that there are a range of barriers in accessing mental health services for Muslims in both majority-Muslim and minority-Muslim societies, such as stigma, negative attitudes towards service providers, a preference for religious healing, and a preference for seeking help from family and religious leaders. However, it is not clear whether there are differences in help-seeking barriers between Muslims residing in majority-Muslim or minority-Muslim societies. Given that help-seeking barriers are likely to involve both individual and environmental factors, it would be useful to compare the help-seeking processes of Muslims from these two groups.

Improving Services for Muslim Clients

Some research suggests that Muslims are concerned about accessing treatment which is not sensitive to their religion and culture (Abu-Ras et al., 2008; Osman, et al., 2005; Weatherhed & Daiches, 2010). Therefore, the provision of culturally and religiously sensitive treatment for Muslims is an important area to be explored.

Culturally competent treatment. The evident role of religion in Muslims' conceptualisation of mental illness, coping responses and support-seeking behaviours indicates a need to examine the cultural competence of services provided for Muslims. Interest in culturally competent approaches has been driven by research which shows large inequities in access and quality of mental health care offered to minority ethno-racial groups (Cooper et al., 2013; Mallinger & Lamberti, 2010). The research reveals that minority groups are often less likely to seek care and tend to withdraw early from treatment (Vega, 2005; Whitley, 2007). Practitioners are increasingly acknowledging the need for mental health services to provide culturally competent care and treatment (Geerlings, Thompson, Bouma &

Hawkins, 2017; Hsieh & Bean, 2014; Huey, Tilley, Jones & Smith, 2014; Sue & Sue, 2008; Whitley, 2012).

Cultural competence is a comprehensive term which defines a set of behaviours, attitudes, policies, and structures in professional services that enable service providers to work effectively when dealing with clients from diverse backgrounds (Cross, Bazron, Dennis & Isaacs, 1989). The term suggests that the individual or organisation values diversity and institutionalises cultural knowledge in addition to conducting cultural self-assessments. For an individual, cultural competence implies being capable of providing effective services in the context of cultural difference. The term indicates an ability to manage the dynamics of difference and adapt services to meet the needs of culturally diverse clients. Cultural competence often focuses on three areas: cultural knowledge, cultural sensitivity and collaboration with the community being served (Flaskerud, 2007).

Cultural knowledge involves learning about the community, whereas cultural sensitivity relates to an ethical stance to respect the beliefs, norms and practices of the people to be served (Tillman, 2006). This involves an awareness of one's own cultural beliefs and practices and an effort to be non-judgemental and respectful in dealing with people whose culture is different from one's own. Professionals who display cultural sensitivity show warmth, empathy, genuineness and collaboration. Research suggests that treatment outcomes are improved when culturally competent approaches are used among various ethnic and racial minority groups (Constantino, Malgady & Primavera, 2009; Gainsbury, 2017; Hsieh & Bean, 2014; Sue, Fujino, Hu, Takeuchi, & Zane, 1991; Takeuchi, Uehara & Maramaba, 1999).

Although there is a significant body of literature which addresses the treatment of clients from ethnically and culturally diverse backgrounds, issues relating to religious identity have received much less attention. For example, Flaskerud (2007) examined a range of

issues including ethnicity, languages, origins, immigration history, level of acculturation, socio-economic status, education, values, beliefs and education. Religious identity and religious beliefs and practices are not mentioned. In view of the significant role of religion in mental health for religious individuals (Hood, et al., 2009; Paloutzian & Park, 2005; Pargament & Abu-Raiya, 2007), awareness of clients' religious identity and affiliation is a fundamental consideration in the provision of mental health treatment services.

There is also an apparent lack of consideration of religious identity in cultural competence training. Delphin and Rowe (2008) detail a model widely used in cultural competence training for community mental health practitioners across four mid-western and eastern states in America. The training workshops aim to be interactive and address modules such as cultural competence and outreach principles, cultural identity and worldview, stereotyping and automatic thinking, and dynamics of difference. The training draws attention to a range of issues in providing culturally competent care in community settings such as race, ethnicity, gender, sexual orientation and age, and highlights other issues of consideration such as housing status, economic class, geography, and employment status. This training encourages mental health professionals to reflect upon their practice with diverse clients. However, there is no mention of religious identity and the need for mental health practitioners to consider the role of religious beliefs and practices in their clients' lives.

Perhaps the tendency not to include religion and spirituality in the cultural competency literature reflects a general ambivalence to address issues of religion and spirituality in psychological therapy (Plante, 2014). Practitioners may be reluctant to explore religious issues in therapy as religion is often considered to be a deeply personal sphere of one's life. Practitioners may consider this as a breach of boundaries, similar to discussing politics. Furthermore, practitioners who are religious themselves may be concerned about being perceived as proselytising or moralising if they devote attention to religious and

spiritual issues in a clinical setting. Additionally, a lack of training may mean that practitioners consider that they are ill-equipped to incorporate religion and spirituality in their treatment approaches. Even so, Plante (2014) asserts that as psychologists are increasingly required to be mindful of diversity in service provision to clients, religious beliefs and spirituality need to be addressed in cultural competency principles and training. Plante (2014) suggests that psychologists consider religious and spiritual issues for their clients just as they would other forms of diversity and cultural difference. He also recommends that psychologists consult with religious leaders and clergy as they would with other professionals, such as general practitioners, school teachers and psychiatrists. Considering the prominent role of religious leaders within the Muslim community, developing communication with them may provide an invaluable source of collaboration.

In health settings, there appears to be a lack of consideration of religious identity for Muslims which can affect treatment outcomes for patients. Mir and Sheik (2010) conducted a three-year ethnographic study to explore the relevance of faith identity to patient-professional management of long-term illnesses for Pakistani Muslims in the United Kingdom. The study involved in-depth interviews, observation and informal contact with 31 patients diagnosed with long-term conditions, 11 family members, and seven health professionals involved in providing care to these patients. The study revealed that religious identity had a considerable impact on decision-making for the Pakistani Muslim patients and on their communication with practitioners. The results showed that both practitioners and patients were unwilling to engage in discussion about religious influences on patient decision-making. This reflected the patients' lack of confidence regarding raising such issues and the professionals' lack of awareness of their importance for treatment outcomes. The study highlighted the way in which religious identity can influence the health beliefs and practices of British Pakistani Muslim patients, and the failure to acknowledge and discuss the

influence on the management of long-term illnesses results in a void of professional knowledge, and inadequate support for patients' decision-making. Such findings draw attention to the significance of being aware of religious issues in order to improve care for patients with strong religious identities.

A perceived lack of culturally competence may serve as a barrier to accessing mental health services (Townes, Chavez-Korell & Cunningham, 2009; Vogel, Wade & Hackler, 2007). Cultural mistrust can have a profound impact on an individual's attitude toward seeking and receiving mental health treatment, compounding the prevalence of unmet mental health needs and an increase in social isolation (Aloud & Rathur, 2009). Muslims may question the intentions of the counsellor and perceive that non-Muslim mental health counsellors lack an ability to understand their cultural and religious beliefs and perspectives, or may fear that counsellors will steer the individual to take action that may be in conflict with their values and belief systems (Weatherhead & Daiche, 2010).

Research suggests that in providing culturally competent treatment to Muslim clients, providers need to adapt services to be responsive to relevant religious and cultural influences, while taking account of the socio-political environment in which they reside. For example, Shier and Graham (2010) explored the ways in which community-based organisations in New York City provided services and supports to Muslims. A total of 19 social workers or related human service professionals participated in face-to-face interviews. The study highlighted that following the 9/11 attacks, public policy and general public perception towards Muslims shifted considerably. Emerging issues included increasing discrimination of Muslims in New York and their fears of detainment and deportation if they accessed government social support. Service provider organisations adapted existing services or created new services for Muslims in response to changing socio-political context. For example, programs were adapted to focus more on advocacy due to violations of human rights, unfair access to

resources, poor employment opportunities and unlawful detainment. Services also developed new initiatives, programs and organisations to change their focus to meet the needs of Muslims. This research draws attention to the need to consider the socio-political context when providing services for Muslim clients.

A lack of culturally competent approaches may be a key reason for the limited use of mental health services among Muslim populations in Muslim-minority societies. The research described earlier by Abu-Ras et al. (2008) investigated the views of 102 Muslims in New York City. The investigators identified the lack of experienced mental health workers familiar with Islamic culture as a reason for the Muslim community seeking assistance from their local imams as opposed to mental health professionals. Furthermore, as indicated earlier, religious leaders are often a first point of contact for Muslims due to the perception that they are able to provide help consistent with their religious beliefs (Youssef & Deane, 2006). Such findings add weight to the importance of mental health providers having an awareness of substantive religious and cultural issues when providing services to Muslim clients.

Research indicates that religiously and culturally competent treatment can improve engagement with mental health services and improve treatment outcomes. For example, Ribeiro and Saleem (2010) created an outreach group to address the observation that Muslim college women in the US suffer discrimination and negative stereotyping and so underutilise university counselling centres. The group provided outreach sessions to 23 Muslim women whose ethnic backgrounds included Turkish, African, Asian, Arab, South Asian, and Pakistani. The outreach group provided an opportunity for the participants to explore issues of self-esteem, body image, marriage, relationships, depression, family issues, careers, time management, including managing prayers with other activities, and living on campus and commuting. The researchers concluded that the outreach group had been successful in terms

of providing support to an underserved population of students who largely had never used university counselling services previously. The participants provided positive feedback regarding the outreach group and all women stated that they would continue to attend if a non-Muslim, but culturally sensitive person led the group. Such findings suggest that tailoring treatment approaches to meet the needs of minority and culturally diverse clients can increase service utilisation. Whilst this study highlights the benefits of providing culturally and religiously appropriate services, a limitation is the lack of detailed analysis regarding the specific aspects of the program which met the needs of the participants.

In order to evaluate the benefits of a culturally and religiously competent program for Muslims, Jozaghi, Asadullah and Dahya (2016) conducted a qualitative study with faith-based program volunteers in Vancouver, Canada, most of whom were mental health and addiction case workers. Semi-structured interviews were performed with eight volunteers in the HOPE Project (Healing Opportunities through Prevention and Education), a service that supports young Muslims struggling with addiction and other mental health issues. A number of themes were identified. For example, there was a need for support programs to target Muslims in Canada due to their exposure to a range of vulnerabilities. Also, stigma associated with substance use and mental health problems was highlighted as a substantial obstacle within the Muslim community to accessing mental health care. Importantly, the volunteers considered that the HOPE project had made progress in overcoming stigma within the Muslim community through raising awareness of mental health. The volunteers asserted that the main strength of the HOPE project was the provision of culturally and religiously appropriate services developed specifically for the Muslim population. This research indicates that there is a range of benefits for Muslims when services are religiously and culturally sensitive. Whilst the reflections of these program volunteers are valuable, there is a

need for research which is grounded in the perspectives and experiences of the Muslims who receive support from such services.

In a recent systematic review, Walpole et al. (2013) examined the main factors involved in providing effective interventions for Muslims in terms of a specific mental disorder, depression. The review focused on areas relevant to practice, including the client's orientation to therapy, gaining the confidence of Muslim clients, therapeutic modalities, and incorporating Islamic and alternative healing approaches. A total of 25 investigations were identified which included qualitative and quantitative designs, as well as service-user views and opinion pieces. The studies were from various locations including Pakistan, Saudi Arabia and Kerala, however, the majority were based in the United Kingdom and the United States. The review indicated that Muslims have religious beliefs about mental illness which are relevant for their treatment and that religion can be a source of assistance for individuals suffering from depression. Yet, studies failed to explore the specific ways in which religion is useful for individuals suffering from depression or whether there are important differences in individuals' use of religion in regard to coping with depression. The authors concluded that the studies were generally methodologically weak. Only one randomised control trial was identified and it had substantial methodological weaknesses. Most of the qualitative investigations were based on case studies and only three studies included a sufficient number of participants to give some insight into a range of service user views. Although the quality of the evidence was generally low, strong assertions were frequently made by the investigators. Furthermore, the advice offered for practitioners about identifying and responding to Muslims' beliefs about depression was contradictory and rarely based upon the evidence. Most of the research did not differentiate between beliefs and values drawn from Islamic teachings, and those influenced by ethnic and cultural practices.

Walpole et al. (2013) asserted that further research is needed to determine the ways that existing therapies can be modified to meet the needs of Muslim clients with depression and also to evaluate the effectiveness of such modified therapies. Given the limited investigations and the poor quality of existing studies, the authors state that research employing a qualitative approach is a necessary first step. They advocate that in-depth exploration with Muslim clients is needed to gain an understanding of the experiences of Muslims in accessing treatment. It is recommended that the next step should be a mixed-method approach in order to test whether Muslims consider that the treatments based upon the qualitative research are appropriate for their needs. Furthermore, Walpole et al. (2013) propose that there is a need for qualitative research to investigate ways to establish a collaborative therapeutic relationship when a client would like to receive both a religious and clinical approach for depression. Lastly, it is important that well-designed, randomised control trials be conducted with Muslim clients.

Whilst there is a significant body of literature regarding the provision of culturally competent care to clients from diverse cultural and ethnic backgrounds, there is a lack of treatments for clients who have a strong religious affiliation. Specifically, research regarding religiously and culturally competent treatment for Muslims is lacking. Given that Muslims are likely to draw upon religious beliefs and practices in their coping, and also seek religious forms of support, treatments are required which address their perspectives of mental health.

Religiously integrated treatment. Treatment approaches which incorporate Islamic perspectives, coping and supports may provide a more effective way to meet the needs of Muslim clients. Religiously-integrated treatments have been developed in recognition of the potential benefits for clients with strong religious affiliations. Such therapies include Spiritual Self-Schema therapy for the treatment of addiction and HIV risk behaviour (Avants & Margolin, 2004), mindfulness, which integrates Buddhist and Western psychological

principles and practices to treat a range of psychological problems (Vøllestad, Nielsen & Høstmark, 2012), and religiously integrated cognitive behaviour therapy (RCBT; Pearce et al., 2015). RCBT is perhaps the most widely studied and employs the same principles and tools as CBT, while drawing on the client's religious tradition to identify and replace unhelpful thoughts and behaviours associated with depressive symptoms. The main tools of RCBT are scripture memorisation, contemplative prayer, challenging thoughts using one's religious resources, religious practices (e.g., gratitude, altruism, forgiveness), religious/spiritual resources and involvement in the religious community. RCBT has been developed for Christianity, Judaism, Islam, Buddhism, and Hinduism (Pearce et al., 2015). According to Pearce et al. (2015), therapies which integrate religious beliefs and practices are at least as efficacious as equivalent treatment approaches.

The increased interest in treatment approaches which are relevant for Muslims has resulted in some researchers proposing models which integrate Islamic beliefs and perspectives. Such models tend to incorporate religious teachings and practices with Western psychological methods, such as CBT. For example, Abu Raiya (2015) developed an approach based on a Quranic theory of personality incorporating the personality structures identified by prominent fifth century scholar Al-Ghazali. This theory proposes that the psyche is composed of five main structures; the evil-commanding psyche, the reproachful psyche, the spirit, the intellect, and the heart. These structures exist in varying levels of awareness: conscious, personal unconscious, and collective unconscious, and are in a permanent state of conflict. Therefore, the goals of psychotherapy are to assist the client to become aware of the conflicting aspects of their self, begin to integrate the conflicting parts and resolve aspects of tension. Similarly, Keshavarzi and Haque (2013) developed a model for treating Muslim clients, based on Al-Ghazali's works. This model conceptualises the self as the interconnecting parts of the spiritual heart, *aql* (cognition), *nafs* (desires) and *ruh*

(soul). The aim of treatment is to intervene at all levels of the self toward development of the spiritual heart. Whilst these models incorporate Muslim beliefs and practices, further research is required. Initially, Muslim clients' reflections on their experience with such approaches would be beneficial to determine whether such models are appropriate for practitioners to employ with Muslims. This would be followed by the modification of treatment approaches with the aim to meet the expressed needs of Muslims. Further to this, more rigorous research would need to be performed to objectively test their effectiveness for a broad range of Muslim clients and a range of presenting issues.

An investigation of religiously-integrated treatment was conducted by Razali, Hasanah, Aminah and Subramaniam (1998). A total of 203 Malays with strong religious backgrounds who were suffering from either anxiety or depression were randomly assigned to either a control or a religiously-integrated treatment group. Both groups were provided with medication, supportive psychotherapy and relaxation exercises. Participants in the treatment group also received religious psychotherapy based upon Islamic principles such as prayer, seeking forgiveness and making repentance, relying on Allah and making supplications. The participants were assessed using the Hamilton Anxiety Rating Scale (Hamilton, 1959) and the Hamilton Depression Rating Scale (Hamilton, 1960). It was found that the participants who received a religious component in the treatment showed a more rapid reduction of symptoms of anxiety and depression. Even so, at six months post-treatment there was no significant difference in improvement between the two groups. The researchers did not provide an explanation for the lack of significant differences between the groups in the long term. It could be possible that the clients needed further follow-up treatment in order to maintain therapeutic gains. Exploring the views of Muslims accessing religiously-integrated treatment is necessary in order to ensure that the revision and

development of such approaches is grounded in Muslims' expressed perceptions and experiences.

The lack of qualitative research regarding Muslims' experiences of mental health treatment is problematic (Abu-Raiya, 2015; Walpole et al., 2013). Gaining an understanding of Muslims' perspectives and experiences is required to ensure that treatments for Muslim clients are relevant for their needs. Studies which rely on self-report scales to investigate the association between religious coping practices and indices of mental health and wellbeing do not provide an understanding of the subjective meaning of religion in mental health, or the way in which religious perspectives and practices are intertwined with their responses to mental illness. Furthermore, conclusions drawn on the basis of standardised tests are limited as most have not been validated with specific populations such as Muslims. Therefore, such measures may not be relevant or accurately capture the main concerns or perspectives of Muslim participants in relation to their mental health. Qualitative approaches are needed in the development of religiously and culturally appropriate treatment. This would be enhanced by including participants residing in both Western societies, such as Australia, and majority-Muslim societies. Investigations of Muslims who reside in societies with different cultural and political contexts would illuminate the similarities and differences in their perspectives, experiences and needs pertaining to their mental health. This would allow for an understanding of the ways in which mental health and treatment is viewed in majority-Muslim countries, which would provide an understanding of the ways in which Muslims' perspectives may shift through the acculturation process. Qualitative longitudinal studies would help to illuminate changes in the coping behaviours of Muslim immigrants through their process of resettlement in Western countries. Such a depth of understanding would allow for the development of approaches which would be relevant for Muslims with varying levels of acculturation.

Conclusion

Research relating to Muslims and their mental health has been limited. In the available research, there are methodological issues which compromise the validity of the findings. This has highlighted a need for research which explores the perceptions and experiences of Muslims in relation to their mental health. There are indicators that Muslims living in Western societies face intense stressors which are risk factors for their mental health. Various reports (e.g., HREOC, 2004; IWWCV, 2008; Ryan, & McKinney, 2007) suggest that Muslims in Australia are subject to a range of challenges and inequalities, and have experienced widespread racism, feelings of fear, isolation and marginalisation. Additionally, many Muslims face challenges as immigrants in their adjustments through the resettlement process, which can be compounded if they face discrimination (Casimiro et al., 2007). Despite this, some evidence suggests that Muslims are generally well-adjusted, appreciate life in their host country and are optimistic (Pratt, 2011; Woodlock, 2011). This leads to a closer examination of the role of religiosity and religious coping in Muslims' mental health. Research shows that religiosity is associated with indicators of wellbeing and mental health and religious coping provides adaptive coping responses.

Studies of Muslims' mental health have tended not to give Muslim participants the opportunity to express their perspectives and concerns. Given that research is in its infancy, investigators (e.g., Abu-Raiya, 2013b; Walpole, 2013) have advocated for qualitative investigations which provide an inductive exploration of Muslims' experiences, perspectives, and concerns related to mental health. The few qualitative studies to date which have focused on Islamic influences on Muslims' mental health beliefs and help-seeking behaviours, have tended to rely on samples restricted to one ethnic group or have included small sample sizes (e.g., Eltaiba & Harries, 2015; Whittaker, et al., 2005). This is problematic as they may not have identified areas of importance for Muslims, who are diverse in terms of ethnic and

cultural backgrounds. There has been limited qualitative research with Muslims in Australia (Youssef & Deane, 2006). Additionally, there is a lack of research which compares the views of Muslims who reside in Western countries with Muslims who reside in majority-Muslim societies. Such a comparison would be valuable in order to distinguish social and cultural context from religious influences on perspectives of mental health. Furthermore, as a large proportion of Muslims residing in Western countries were born in majority-Muslim societies. It would be useful to explore the perspectives of Muslims within both societies in order to develop treatment programs which meet the needs of Muslims in Western countries with varying levels of acculturation. Finally, rather than focus on one ethnic group, a comparative exploration provides the opportunity to gain a fuller picture of Muslims' perspectives and experiences of mental health and illness. The strength of this approach is that it can identify common themes which cut across diverse groups of Muslims who reflect a range of ethnic, cultural and environmental influences. This can assist in the development of broadly based models and theories of Muslims' attitudes toward mental health.

Research which investigates Muslims and mental health requires an approach that can elucidate the complexities of religion and spirituality. Qualitative methods allow for research designs that are relatively open and flexible, thereby facilitating exploration and description of complex issues (Flick, 2008). These methods enable phenomena to be investigated in-depth, rather than being reduced to single variables. Face-to-face interviews are particularly useful for exploring participants' personal experiences and viewpoints as they provide an opportunity for respondents to discuss in detail the ways in which they make meaning of events in their lives (Patton, 2002). Furthermore, participants are able to voice views, concerns and attitudes that may be otherwise overlooked (Tracy, 2013). Such methods of inquiry may assist in deconstructing stereotypes and assumptions of Muslims and allow for a more accurate portrayal of their needs. Furthermore, the data gained not only provides a

depth of understanding of individual processes, but also allows for cross-comparison. As themes are inductively identified from the data itself, explanatory theories of phenomena can be developed (Tracy, 2013).

The following chapter provides an overview of the methods used in the research. This includes the aims of the research, the assumptions of the research, the data collection methods and data analysis procedures.

Chapter 4

Research Methods

The preceding chapter reviewed research focusing on Muslims and mental health and identified a lack of related research (Abu-Raiya, 2013; Khawaja, 2016). This is concerning, as whilst there has been a heightened political and media focus on Muslims in the West in recent years, there has been limited formal exploration of their attitudes and experiences (Abu Raiya & Pargament, 2011). Specific gaps in the research include a limited understanding of the meaning of mental health problems for Muslims, a failure to fully examine the nature of their coping responses in light of Islamic beliefs, and a lack of identification of factors that influence their help-seeking. This research addresses these gaps by examining the views and experiences of Muslims regarding their mental health in the context of a Muslim minority country (i.e., Australia) and also in the majority-Muslim countries of Indonesia and Jordan.

This chapter begins by identifying the aims of the research and the focus of the inquiry. The rationale for choosing a mixed-methods design, underpinned by grounded theory methodology, is then discussed. This includes an exploration of the philosophical assumptions, perspectives and principles that framed the research practices. The research program involves data collected using face-to-face interviews and an online survey. In this chapter, each research setting is described in turn including a description of the participant recruitment and data collection procedures. The final section of the chapter describes the process of data analysis.

Research Questions

In seeking to understand Muslims' perspectives on mental health and mental illness, the central question explored was, “What are the perceptions and experiences of Muslims in regard to their mental health and accessing treatment services?" This question was

deliberately broad in order to maintain an open perspective to the phenomena under investigation (Glaser, 1978, 1992; Strauss & Corbin, 1990, 1998). This broad perspective was considered useful as it enabled the identification of key concepts embedded within the data and avoided pre-empting the findings or imposing pre-conceived categories onto the data. This stance of openness is consistent with grounded theory methodology, as it allows the direction of the research to be guided by the participants in regard to what is important to them (Charmaz, 2006). As the research progressed a range of more specific questions related to the focus of the research were considered. These included;

- What are the ways in which Muslims make meaning of their mental health difficulties?
- What do Muslims perceive as having an impact, both positive and negative, on their mental health?
- What are the coping responses of Muslims when faced with mental illness?
- What are the attitudes of Muslims towards mental health treatment services?
- What are the experiences of Muslims in accessing mental health services?
- What are the barriers for Muslims in accessing mental health treatment?
- To what extent do Muslims consider that mental health services cater for the needs of their community?
- What kinds of community and religious supports do Muslims access in coping with mental health problems?

The intention of the research was to produce findings which would illuminate these areas of inquiry and inform a coherent understanding of relevant issues for Muslims and their mental health.

Qualitative Research Design

The nature of investigating subjective phenomena warrants a qualitative methodology. Qualitative research poses open-ended, exploratory questions to investigate the meanings and experiences that people give to their world (Flick, 2008; Patton, 2002). This study is firmly situated within qualitative enquiry as it strives to understand the perspectives of Muslims in relation to their experience of mental health and accessing treatment services.

The ways in which individuals make meaning of their experiences are "complex and multidimensional" (Maykut, & Morehouse, 1994, p.38) and require research methods which illuminate such phenomena. Particularly as this research was exploratory, the use of a qualitative approach was fitting to enable an inductive, emergent process (Charmaz, 2006; Liamputtong, 2010). A qualitative approach is particularly valuable when undertaking research with minority groups due to the opportunity to represent their experiences as they perceive them, rather than framing them through the interpretation of dominant cultural viewpoints (Liamputtong, 2010).

A further advantage of qualitative research is that it provides an opportunity to develop theories which are anchored in participants' real-life perspectives and experiences (Charmaz, 2006). Individuals from ethnically diverse or minority communities may be suspicious of research and the motives of researchers and this is a relevant concern for Muslims (Aly, 2010). If undertaken carefully, qualitative methods such as interviewing enables researchers to build rapport, establish trust and convey sensitivity to the participants (Liamputtong, 2010). In situations where researchers are considered "outsiders", reducing distrust toward the research and the researchers is essential in order to effectively engage the participants (Liamputtong, 2007).

Grounded Theory

There are numerous types of enquiry that are considered to be qualitative with the field continually evolving (Denzin & Lincoln, 2000). Among the range of methods available, grounded theory is ideal for inductive, exploratory research where there is a substantive lack of empirical knowledge (Charmaz, 2006). Investigators undertaking grounded theory research avoid imposing pre-existing assumptions, themes or theories onto the data. Rather than applying preconceived categories, grounded theory processes aim to identify core concepts that are embedded within the data. This approach assists the researcher to be open to the phenomena under investigation (Charmaz, 2000, 2006). Such a process allows the participants' main concerns to emerge directly from the data and is therefore consistent with the intention to give them a "voice". A fundamental principle of grounded theory is to remain theoretically sensitive (Glaser, 1978) which involves embarking upon the research without a preconceived notion of what will be found. Straus and Corbin (1990) defined theoretical sensitivity as the ability to recognise the points of importance in the data and understand the meanings participants assign to their personal experiences. As grounded theory proceeds beyond descriptive detail towards abstract conceptualisation, the methodology offers a means of ensuring the abstraction of a substantive theory that has direct relevance within the area from which it was derived. This is an advantage for this research as it was imperative that the final conceptualisations of the findings were grounded in the views and experiences of the participants.

Grounded theory remains one of the most influential and widely used approaches in qualitative research (Otkay, 2012). Originally developed by the sociologists Glaser and Strauss (1967), the application of grounded theory has spread to a variety of disciplines, including social, clinical, counselling, organisational and environmental psychology (Henwood & Pidgeon, 2003). The introduction of grounded theory was considered

revolutionary at the time as it effectively challenged the dominant positivist conception that the scientific method involves the falsification of competing theories. In contrast, grounded theory involves using methodological processes to understand complex, subjective phenomena. Through this systematic and inductive process, theories are developed directly from the data (Charmaz, 2006; Glaser & Strauss, 1967).

The original version of grounded theory, or "classic" grounded theory, was based on the theoretical underpinnings of symbolic interactionism, a sociological approach developed between 1920-1950 that proposes that meaning is created and derived from social interactions (Blumer, 1969; Dennis & Smith, 2015). Symbolic interactionism assumes that people construct their realities through social interactions in which they use shared symbols (e.g., words, clothing, gestures) to communicate meaning. Since its introduction, grounded theory has continued to be modified in its application, particularly through the influential writings of Glaser (1978, 1994, 1998), Strauss and Corbin (1990, 1998) and Charmaz (2000, 2006).

Grounded theory data analysis involves the fundamental steps of coding raw data and the constant comparison of emerging concepts. The initial coding process involves labelling raw data whereby all incidents in the data are coded, so that the data are fragmented into comparable segments. These codes are not preconceived and applied to the data, but rather they arise through the researcher's analysis (Charmaz, 2006). The main ideas conceptualised in the grounded theory may not be voiced explicitly by participants, but instead are abstracted from the data (Glaser, 1998). Constant comparison is applied throughout the analysis process and involves moving across data and comparing fragments of data against each other, then data with codes, codes with categories, and categories with categories (Charmaz, 2006). Ideally, each stage of comparison raises the level of abstraction of the analysis. In the stage of theoretical coding, the researcher seeks to find the relationships between concepts. This iterative process helps to focus data collection and conceptualise the collected data in the

memos (written reflections of the on the work in progress) and mapping of concepts (visual representations of the findings). In this way, grounded theory strategies influence the kinds of data to collect and the ways in which data are collected. Theories are derived inductively through a concurrent process of data collection, coding, conceptualising and theorising, wherein new data are constantly compared to emerging concepts until no new themes, categories, or relationships are being discovered. In order to develop theory which is grounded in the data, sampling and data collection is focused on theory construction as opposed to population representativeness (Charmaz, 2006). Therefore, the theory which is developed aims to be explanatory and predictive in the area under investigation (Strauss & Corbin, 1998). Rather than being generalisable, grounded theories aim to conceptualise patterns of behaviour that will account for the variation in the data. Therefore, the substantive theory aims to be relevant to the population from which it was developed (Strauss & Corbin, 1998). A fuller description of this process as it applies to this study will be provided later in the chapter (see pp. 121-126).

In the early 1990s, Glaser and Strauss differed in their perspectives regarding the theory-generation aspects of grounded theory (Glaser, 1992; Strauss & Corbin, 1990, 1998). According to Glaser (1978), grounded theory relies on empiricism, whereby categories emerge from the data to reveal a basic social process. Strauss developed an alternative perspective with his colleague Corbin (Corbin & Strauss, 1990; Strauss & Corbin, 1998) which emphasised the active role of the researcher in drawing out the grounded theory from the data. The main divergence of Straussian grounded theory to classic grounded theory was the addition of "axial coding" which is a more systematic approach in the data analysis process. This stage follows open coding, where the researcher applies a coding paradigm to identify conditions, context, action and interactional strategies, intervening conditions and consequences (Strauss & Corbin, 1998). These processes have been criticised as forcing the

data into the development of a theory through a mechanistic approach (Bryant & Charmaz, 2007).

Charmaz (2000; 2005; 2006), a former student of Glaser and Strauss, developed a version of grounded theory characterised by a constructivist philosophy. Constructivist grounded theory maintains the original guidelines of grounded theory for conducting research and analysis, however, it moves away from the positivist assumptions expressed in the early formulations of the methodology. Charmaz (2000) describes constructivist grounded theory as situated between postmodernism and positivism and, as such, argues that it is relevant for conducting research in the 21st century. Charmaz (2006) refutes the assumptions of classic grounded theory (Glaser, 1978; 1992; 1998; 2003) that the researcher is an entirely neutral observer seeking to discover truth which resides in an external reality. Rather, she contends that grounded theory studies seek to understand the experiences and perspectives of research participants and the ways in which they construct their reality. As such, any processes identified through systematic research depend on the interpretation made by the researcher who must be able to identify from whose "vantage points" these processes are seen (Charmaz, 2006, p. 20).

Charmaz (2006) argues that reality needs to be presented as interpretive understanding, given that it is filtered through the lens of the researcher. This stance assumes that the researcher is active in the research process, and the interpretation of the data is shaped by the interactions between the researcher and the participants (Guba, 1990). This constructivist-interpretive perspective acknowledges what the researcher brings to the research and what they see within the data.

Charmaz's (2006) approach suggests a level of acceptance regarding researcher subjectivity. According to Charmaz (2006), the researcher's subjectivity needs to be

acknowledged as a present factor throughout the data collection and analysis process. She notes that although a level of bias is inevitable, bias only becomes troublesome when the researcher's assumptions, views and perspectives drive the interpretation of the data. Therefore, the researcher needs to be mindful of the ways in which bias can intrude upon their interpretations. This approach emphasises a need for the researcher to be cognisant and reflective of their subjectivity throughout the analysis and write-up. Whilst Charmaz (2006) dispenses with the notion of absolute objectivity, she asserts that the researcher should adopt careful and close analysis in order to identify the core meanings which are embedded within the data.

Whilst there is no one "right" version of grounded theory, the different approaches and assumptions require the researcher to select an adaptation which best suits the aims of each particular study (Breckenridge, Jones, Elliott, & Nicol, 2012). For this research, constructivist grounded theory is most consistent with the objectives and assumptions underlying the research. Investigating Muslims' perspectives and experiences requires an approach which recognises that such phenomena are diverse, complex and fluid. In light of this, the current research was conducted with the view that there are multiple realities within the social world. A constructivist grounded theory approach was considered to be the most appropriate in order to present an interpretive understanding of the phenomena under investigation. A constructivist approach to grounded theory was an ideal fit for the current research as this takes into account the researcher's perspectives and experiences whilst remaining sensitive to emerging theory (Charmaz, 2006).

As with any form of research methodology, grounded theory has its limitations. Grounded theory has been criticised for the generation of theory, particularly in relation to the notion that the categories which form the basis of the grounded theory *emerge* from the data (Dey, 1999). This has been raised as a problematic assumption, as the process is

inherently subjective and relies upon the researcher's abilities (Suddaby, 2006). In addition, grounded theory is time-consuming in terms of data collection and analysis. Coding and memo writing are lengthy processes, particularly if they are undertaken without the use of computer software programs. Charmaz (2006) encourages researchers to perform coding by hand as a way of maintaining a close connection to the interpretation process and a sense of the data as a whole. Despite these limitations, the inductive, emergent processes of grounded theory were determined to be most fitting for the aims of the research. The methodology of grounded theory was therefore applied carefully, and I as the researcher aimed to be continually reflexive in the analysis and interpretation of the data.

A Constructivist Paradigm

As noted, a constructivist perspective provided the conceptual basis for exploring the perspectives and experiences of Muslims towards mental health and treatment services. The aim of a constructivist perspective is to "understand the complex world of lived experience from the point of view of those who live it" (Schwandt, 1994, p. 222). A constructivist standpoint assumes that individuals make meaning of their experiences, and that this meaning is multiple and layered (Charmaz, 2006; Guba, 1990). Therefore, the constructivist approach requires that the researcher interprets the way in which individuals make meaning of their experiences (Guba & Lincoln, 1998).

In this thesis, the design facilitated the presentation of the participants' viewpoints and experiences as closely as possible to ways in which they perceived them. Throughout the data collection process, the participants demonstrated the diverse ways in which individuals reflect upon their experiences through their interactions and understanding of the world around them. This approach invited participants to explore their conceptualisation of mental

illness and coping, which provided insights regarding the ways in which they make meaning of their experiences, and how their meaning differs from others.

Constructing Grounded Theory

In applying grounded theory, existing psychological theories are not drawn upon to guide the data analysis. The researcher inductively develops theory through themes and concepts which emerge from the data so that the final theory is "grounded" in the data (Glaser & Strauss, 1967). This process requires a set of methodological procedures that enables a progressive abstraction of concepts that fit the data (Glaser, 1998).

Although classic grounded theory asserts that researchers should avoid drawing upon existing theories and literature, a number of grounded theorists assert that researchers cannot entirely avoid earlier theories and empirical studies in the areas of their research interests (Bryant & Charmaz, 2007; Charmaz, 2006; Clarke, 2005; Dey, 1999; Henwood & Pidgeon, 2003). For example, Henwood and Pidgeon (2003, p. 138) propose adopting a stance of "theoretical agnosticism", as opposed to proceeding with the assumption that the research will be untouched by earlier ideas. In line with this recommendation, I, as the researcher, endeavoured to maintain a theoretically agnostic approach in the current research and avoid seeing the data through existing theories and ideas. That is, although a preliminary review of the literature was performed in the early stages of the research, an in-depth examination of previous studies was only undertaken after the data analysis was completed.

Grounded theories aim to provide an explanation directly related to the data from the particular area from which it has been generated. In contrast, formal theories tend to be more abstract and provide an explanation which can be applied to a broader range of concerns and problems (Strauss & Corbin, 1998). Glaser (2004, para. 64) argues that "all substantive grounded theories have general implications far beyond the more local population used in the

research". According to Charmaz (2006), formal theories can be developed from conceptualising the results from a range of substantive grounded theories. For the purposes of this study, the aim was to generate a theoretical conceptualisation which can explain Muslims' perspectives and experiences of mental health and treatment needs, whilst allowing for innumerable individual differences.

Reflexivity

Reflexivity is an essential element in undertaking qualitative research (Flick, 2009). Being reflexive involves a continual process of reflecting critically on the self as the researcher. Reflexivity entails transparency regarding the researcher's subjective approach and interpretations. This requires that the researcher engages in an inward examination of their own lived reality and experiences, and explores the way that this influences the research process. Reflexivity in research is consistent with a constructivist interpretive perspective, which acknowledges the researcher's active role in constructing knowledge throughout the research process (Braun & Clarke, 2013). Theorists (i.e., Charmaz, 2006; Strauss & Corbin, 1998) assert that it is not possible for researchers to completely separate themselves from who they are, what they know, or from their experiences. In order to assist with being continually reflexive, Strauss (1987) recommends the writing of "memos" throughout the research process. Memos are written notes which consist of ideas, thoughts, comparisons and connections that arise through the data collection process and provide the basis for writing a first draft (Charmaz, 2006). During data collection memo writing provided a helpful way for me to reflect upon my own underlying choices, viewpoints and assumptions (see p. 125 for a detailed description of this process).

Reflexivity entailed acknowledging what I brought to the research process, such as my perspectives, values and attitudes. Face-to-face interviews were the main data collection

tool and I acknowledge that this is an active process whereby the outcomes are constructed between the researcher and the participant (Patton, 2002). The questions which I reflected upon included, "how do my beliefs and experiences impact on the research process?", and "what shapes the questions I choose to study and my approach to studying them?"

Throughout the research journey, I strove to be mindful of my experiences and worldview and acknowledge my personal and professional interests. These included my beliefs and practices as a convert to Islam, my experiences with the Muslim community in Australia and my views regarding access to mental health treatment for minority groups. In reflecting upon these areas of influence, some of the underlying assumptions that I brought to this work are acknowledged. The work is informed by my experiences as a counsellor of children, adolescents and adults in the Australian Muslim community. Furthermore, as a convert to Islam, I am connected to parts of the Muslim community in Melbourne, Australia. My contact with the Australian Muslim community on both personal and professional levels has resulted in a high degree of familiarity with Muslims. This level of familiarity poses a risk of taking certain Islamic beliefs and practices for granted. Being a part of the community in which one is conducting research can be problematic, as this opens the possibility of relying on previously held assumptions and prior knowledge, which has the potential to steer the focus of the research and interpretation of data (Liamputtong, 2010). As such, it was crucial that I was mindful that these previously gained understandings could interfere with objective and inductive data analysis (Strauss & Corbin, 1998). I recognised that it was my responsibility as a researcher to be reflexive about what I brought to the research process, the aspects that were focused upon and the way in which these aspects were interpreted. In this regard, participants were informed at the beginning of the interviews that I would seek clarification of their viewpoints, especially in instances where I perceived that there was a tendency to assume understanding of certain terms or concepts. I found that this approach

assisted in questioning my assumptions, while verifying the meanings of the participants' comments during the interviews. This approach was useful in each of the settings, namely Australia, Indonesia and Jordan. It appeared to have the added benefit of conveying to the participants a genuine interest to understand their perspectives and experiences.

Approaching the research process as an "insider" can be advantageous in gaining access to one's own community (Liamputtong, 2010). My experiences as a counsellor within the Australian Muslim community meant that I was exposed to their concerns in relation to their mental health and accessing treatment. Indeed, it was these experiences that prompted me to embark upon the current research. There are potential benefits in conducting research in the community of which one is a part, as one has the opportunity to gather rich data through being part of the in-group. This positioned me to see the "participants' lives from the inside" (Charmaz, 2006, p. 14) whilst at the same time acknowledging that it was not possible to exactly replicate their experiences and viewpoints. Being seen as an "insider" was also beneficial in addressing participants' concerns about being a part of a research project. This was an advantage, as participants expressed a sense of trust and comfort in sharing their perspectives and experiences with an individual from their community.

In Jordan and Indonesia, I shared a common faith with the participants; however, I was mindful that I was situated as an "outsider" in terms of my cultural and linguistic background. I was cognisant that there was a range of difficulties being an "outsider" in terms of a lack of a shared social, cultural and linguistic understanding. As the interviews were not conducted in the participants' native language, there was the potential for language barriers. Furthermore, outsiders may not understand certain cultural perspectives, and may be less equipped to undertake research in a culturally responsive manner (Banks, 1998). In contrast, insiders might be better equipped to ask more meaningful questions due to shared cultural knowledge and language, and able to interpret subtleties in communication. This can

allow for a more nuanced, authentic understanding of the phenomena under investigation (Coloma, 2008). As a consequence, I was mindful to consider the possible negative aspects of conducting research as an "outsider" in Indonesia and Jordan.

Whilst I was considering the potential problems with conducting research as an "outsider", I was also aware that this position can result in positive outcomes. "Outsiders" to a cultural or ethnic group can bring a distinct lens to scrutinise certain aspects which an "insider" fails to recognise due to their familiarity (Liamputtong, 2010). An outsider may also consider alternative perspectives of cultural or community norms and raise questions which require more detailed explanations (Banks, 1998). Furthermore, if trust is gained, participants may be more willing to make honest disclosures to an outsider if they perceive that the researcher will not be mixing in their social circles and communities. In regards to this research, I noticed that once trust was established with the participants in Indonesia and Jordan, they appeared comfortable to divulge information that they may not generally reveal to others within their communities.

It is useful to note that the "insider / outsider" dichotomy might fail to adequately describe circumstances where researchers cannot neatly be described as either an "insider" or an "outsider". Liamputtong (2010) asserts that a researcher can simultaneously be both an insider and outsider to a minority group, and therefore the term "partial outsider" is a more accurate description. This can occur when a researcher shares certain characteristics with the group being studied, while he or she is also situated as an outsider for other reasons. In terms of the research, "partial outsider" was a more accurate description of my position as a researcher in Indonesian and Jordan. I experienced a level of mutual understanding and connection on the basis of a shared faith and religion. However, I was outside the participant grouping on ethnic, cultural and linguistic levels. As such, it was essential that I maintained an awareness of my cultural perspectives and the ways in which my insider / outsider status

impacted upon the research process. I was conscious that my upbringing in a traditional nuclear family in a Western liberal society differed significantly from the more interdependent cultures of Indonesia and Jordan (Gregg, 2007; Jetten, Postmes & Mcauliffe, 2002). I was mindful that the communities I entered might not have had positive interactions with outsiders such as myself, coming from an English-speaking, Anglo-Saxon background.

In view of this awareness, I was cognisant of embarking upon the data collection process in a culturally sensitive manner. Research that is culturally sensitive includes the main component of "culturally congruent research methods, culturally specific knowledge, cultural resistance to theoretical dominance, culturally sensitive data interpretations, and culturally informed theory and practice" (Tillman, 2006, p. 269). Acquiring cultural knowledge is an essential part of conducting cross-cultural research, which includes social, familial, cultural, religious, historical and political backgrounds, as this serves to ground the cross-cultural knowledge in a particular context, without which the phenomena cannot be fully understood (Im, et al., 2004). In order to embark upon the research in a culturally informed way, I read extensively regarding Indonesian and Jordanian history and culture. The cultural knowledge gained was necessary to develop an awareness of areas of importance when conducting research in these communities, particularly in relation to social etiquettes. Cultural immersion can assist a researcher to gain an in-depth understanding of the community in which one is performing research (Hogan, Dolan & Donnelly, 2011). In this regard, I was able to spend time mixing within the local community in each setting, which proved to be helpful in learning about the people and gaining some understanding of cultural norms and practices. I spent a total of three months living in Jordan and two months in Indonesia, which provided me with an opportunity to gain cultural knowledge through interactions and discussions with locals. I also engaged in discussion with individuals in the

communities in which the research was performed in order to clarify cultural issues of importance.

Liamputtong (2010) highlights the value of researchers collaborating with community leaders and stakeholders. Stakeholders can assist researchers to gain access to potential participants and help develop essential connections. Through their cultural and local knowledge, they can highlight key issues and concerns within their communities. In the study, the stakeholders were helpful to allay participants' concerns about being involved in the research and assure them that the researcher was trustworthy with no ulterior motives. Liamputtong (2010) suggests that when conducting research with ethnic or cultural minorities, it is helpful to spend some time getting to know the participants before collecting data. Making efforts to build a trusting relationship is essential in order to gather reliable information (Liamputtong, 2007; Walsh-Tapiata, 2003). In view of this, I established contacts with stakeholders in the communities in which I conducted the research. I was able to do this through acquaintances who had connections to stakeholders in each of the communities. Furthermore, the participants were engaged in informal discussions with me prior to conducting the interviews in order to build rapport.

In regard to the qualitative data collection phase, face-to-face interviews were ideal as they allowed me to build rapport, gain trust and convey cultural sensitivity to the participants. In entering the research with participants in Australia, Indonesia, and Jordan, the focus was to maintain a stance of openness and "give voice" to the participants (Strauss & Corbin, 1998). My orientation in this process was that each individual’s perspective and experience is unique. The notion of giving "voice" to convey participants' viewpoints can be problematic, as all reports are mediated by the researcher (Bogdan & Biklen, 2007). Key questions for reflection during the research included the extent to which differing perspectives were represented and which comments were omitted and why. I was conscious of the temptation

to present the data in a way which suited my views and careful of the way contradictory responses were addressed. During this process, I continually reflected on the notion of "giving voice" to the participants, and strove to be true to their meanings and the trust placed upon me as a researcher. I aimed to present the participants' perspectives as closely as possible to the meanings as they were intended. The constructivist approach to grounded theory attempts to address the issue of researcher bias by maintaining transparency in the way that the researcher's subjectivity influences the research process and interpretations. In order to maintain this level of awareness, data were compared with other data, different data collection methods were utilised, and multiple and varied representations of the participant cohort were interviewed. My reflections and interpretation of the data were also overseen by research supervision. Throughout the process, my extended notes (i.e., memos) and concept maps were reviewed by my research supervisors, and the ensuing discussions assisted me to maintain a critical, analytic and reflexive position.

Rigour

Rigour is the application of the research method in an accurate way in order to ensure the quality of the research processes and outcomes (Ezzy, 2002). In striving for rigour in the research, grounded theory methods were carefully applied. The core aspects of a grounded theory study include coding, constant comparative analysis, memo writing and purposeful sampling (Strauss & Corbin, 1998). Each of these methods are described in greater detail later in the chapter (see pp. 121-126).

Briefly, purposeful sampling involves selecting participants on the basis that they possess certain characteristics, qualities or experiences that can facilitate theory development. In contrast to convenience sampling, purposeful sampling involves the researcher deliberately seeking particular participants in order to allow for the emerging concepts to be more fully

explored. The goal of purposeful sampling is to select cases which will allow exploration of the questions under study (Patton, 2002). Purposeful sampling, as used in this research, is described by Patton (2002, p. 234) as "maximum variation sampling", which involves exploring themes that cut across heterogeneous cases. Purposefully targeting participants who will aid the researcher to understand the area under investigation is consistent with the aims of grounded theory (Creswell, 2003). Qualitative research generally seeks to reflect diversity within a particular phenomenon or population, rather than aim for statistical generalisability or representativeness. In this research, Muslim participants were involved from a diverse range of ethnic, cultural and linguistic backgrounds. Muslims in Australia are a heterogeneous group. Whilst being united by a common faith, they vary on a range of factors, including cultural and linguistic influences, educational background, level of acculturation and socio-economic status (Hassan, 2015). In consideration of this diversity, the research sought to include participants who represented a range of educational, socio-economic, cultural and linguistic backgrounds.

The inclusion of participants from both Muslim-minority and Muslim-majority countries ensured that the research gave voice to a diverse representation of Muslims. As indicated in the literature review, there is a need for research which provides comparative analysis between the views and experiences of Muslims who live in different parts of the world. The data gained from these sources allowed for continual comparison of emerging concepts and categories. Undertaking research with Muslim participants in three countries assisted in identifying where concepts and categories cut across differing sources. The findings were therefore based upon the accumulation of the participants' perspectives and experiences.

This research used a mixed methods design consisting of face-to-face interviews and an online survey. The use of mixed methods is compatible with a grounded theory approach

of using various data collection methods and types of data (Charmaz, 2006). Social phenomena are complex and utilising a variety of methods can provide a better understanding of these complexities than using either approach alone (Patton, 2002). This is consistent with *triangulation*, which refers to combining different sources and methods to strengthen a study by revealing different aspects of the phenomena under investigation (Lincoln & Guba, 1985). The use of different methods has the potential to provide a "fuller picture" (Hammond, 2005; p.239) of the phenomena and can help to explain seemingly contradictory results. Consequently, the interviews provided a way to gather rich data from a variety of participant sources and so to identify key themes. The survey items were developed from the interview data to further explore these themes in a large sample.

As each approach to data collection has its own strengths and weaknesses, using different methods can minimise the disadvantages of using one method alone. For example, for face-to-face interviews the presence of an interviewer may influence the interviewees' responses to certain questions (Patton, 2002), whereas for self-administered surveys, respondents may answer questions carelessly without the presence of an interviewer (Ornstein, 2013). Therefore, using a combination of data collection approaches ensures that the research is less vulnerable to such limitations.

Denzin (2009) notes that studying phenomena on different dates, at varying places and from a range of sources is a useful way to enhance the validity of a study. The utilisation of both face-to-face interviews and an online survey strengthens the credibility of the findings (Denzin, 2009). This permits the data to be cross-checked for consistency and to determine the extent that the perspectives expressed by participants in the face-to-face interviews were shared by a larger sample. Comparing the results from a range of sources collected through different methods assists in validating the findings by highlighting points of convergence and divergence across the data (Patton, 2002). It must be noted that there are difficulties when

different sources of data reveal divergent findings, and the interpretation of these differences needs to be made through careful analysis with explanations that are grounded in the data.

The validity of the concepts derived from the data were checked through the method of constant comparison. This involves regularly comparing the views and experiences of the participants across the data in order to illuminate the nuanced differences of the phenomena. The process of coding, which is described later in the chapter (see pp. 122-125) enhanced the internal validity of the findings. As Patton (2002) recommends, I constantly returned to the raw data to ensure that my interpretations were accurate reflections of the phenomena under investigation. In the latter stages of the analysis, the findings of the study were compared to current literature. This provided an opportunity to make comparisons between my explanations and those contained the relevant research, highlighting areas where my conclusions confirmed, extended, or diverged from the literature (Charmaz, 2006; Strauss & Corbin, 1998). The participants' own words were used in the final presentation of the results in order to enhance the validity of the reported findings (Backman & Kyngäs, 1999).

Data Collection and Analysis

Face-to-Face Interviews

Face-to-face interviews were used as the main data collection tool to gain an understanding of phenomena which are not observable, such as feelings, thoughts, viewpoints and attitudes. Exploring the meaning of participants' views and experiences through interviews can be a valuable way to gain rich data (Charmaz, 2006; Patton, 2002). The underlying assumption in collecting data through interviews is that the perspectives of others are "meaningful, knowable, and able to be made explicit" (Patton, 2002, p. 341).

There are multiple ways that the researcher can conduct interviews. Interviews in a grounded theory study typically involve inviting the participants to explore their experiences

or perspectives around a topic (Charmaz, 2006). Interviews are, in essence, directed conversations (Lofland & Lofland, 1995). In this project, the *interview conversation* (Charmaz, 2006) was adopted as a way to conduct an in-depth exploration with participants. This approach is consistent with the constructivist perspective and involves drawing out the participant's interpretation of his or her experiences. Throughout the interviews, I was mindful to verify the meanings of the participants' comments in order to check my understanding of their interpretations (Charmaz, 2006). According to Charmaz (2006), verifying the accuracy of understanding is a useful way for researchers to assess their inferences with the participants and this process of verification assisted in checking my assumptions and understanding of the participants' comments throughout the course of the interviews.

Interviews in Australia: Participant Recruitment and Data Collection Procedure

In order to recruit participants from a diverse range of backgrounds, I approached a number of Islamic organisations in Melbourne. These included Islamic community centres (n = 2), mosques (n = 4), an Islamic school (n = 1), religious study groups (n =3), and a Muslims' Arabic language study group (n = 1). At each organisation, the researcher discussed the project with both groups and individuals, and extended an invitation for participants. When individuals expressed an interest in participating, the researcher further explained the nature of the research and clarified the inclusion criteria.

The criteria for this study were that potential participants were 18 years or above, residing permanently in Australia and considered themselves to be "practising" Muslims. No objective criteria were applied to being a "practising" Muslim. The notion of a "practising Muslim" can mean different things to different people and as such tends to be a subjective appraisal (Abu-Ras & Hosein, 2015). It was therefore considered appropriate that this was

determined by the participants. The participants were informed that it was not a requirement that they had had previous experience with mental health issues or treatment services; rather that their views, perceptions and attitudes were sought regardless of their prior knowledge of mental illness or experience with mental health services. Recruitment continued until the researcher had included participants who represented a range of cultural, educational, linguistic and educational backgrounds. The participant characteristics were documented throughout the research process.

Between 2009 and 2011, 20 Australian Muslims were interviewed consisting of 10 males and 10 females ranging from 22 to 50 years of age (M = 32.70; SD = 9.69). The participants represented a range of cultural and linguistic backgrounds including Lebanese (n = 7), Turkish (n = 1), Albanian (n = 1), Eritrean (n =1), Senegalese (n = 2), Pakistani (n = 2), Egyptian (n = 2), Palestinian (n = 1), Chinese (n = 1) and Australian Anglo-Saxon (n = 2). Most of the participants (n = 17) were born into Muslim families with three being converts to Islam. The participants who had converted were between 16 and 24 years of age at the time that they had converted. The majority of the participants (n = 15) were born and raised in Australia while five were born overseas and migrated to Australia as adults. The participants were given gender and culturally appropriate pseudonyms to maintain anonymity while highlighting their distinctive voices and assisting the reader to envision them in their worlds (Charmaz, 2006; Saldana, 2011).

Australian Participants: Pseudonyms and Descriptions

Participant 1: Hanan

Hanan is a 30-year-old female, born and raised in Australia by parents of Lebanese origin. At the time of the interview her highest level of education was a post-graduate qualification and she was employed full-time in a professional capacity. She is married and

living with her husband. Hanan reported experiencing symptoms of depression when she was 25 years of age and had sought the services of a private psychologist. She discontinued treatment after the first session.

Participant 2: Nadia

Nadia is a 32-year-old female, born and raised in Australia by parents of Anglo-Saxon origin. She converted to Islam at 19 years of age. At the time of the interview she was a single mother of two children and her highest level of education was a secondary schooling` certificate. Nadia reported experiencing symptoms of depression at 30 years of age and engaged in counselling services with a non-Muslim private psychologist.

Participant 3: Amin

Amin is a 42-year-old male, born and raised in Australia by parents of Lebanese origin. At the time of the interview he was married with four children. His highest level of education was a post-graduate qualification and he was employed full-time in a professional capacity. He reported no prior personal experience with mental illness or mental health treatment services.

Participant 4: Rayann

Rayann is a 28-year-old female, born and raised in Australia by parents of Lebanese origin. At the time of the interview she held a post-graduate qualification and was employed full-time in a professional capacity. She was married with three children. Rayann reported no prior personal experience with mental illness or professional mental health services.

Participant 5: Tasneem

Tasneem is a 25-year-old female, born and raised in Australia by parents of Albanian background. At the time of the interview she was engaged in home duties and her highest

level of education was a diploma. She was married with two children. Tasneem reported experiencing symptoms of depression at 19 years of age, however, she did not access professional mental health treatment services.

Participant 6: Kareema

Kareema is a 36-year-old female, born and raised in Australia by parents of Anglo-Saxon background. She converted to Islam at age 25 and was married with four children. At the time of the interview her main occupation was home duties. Kareema reported no prior personal experience with mental illness or professional treatment services.

Participant 7: Layla

Layla is a 28-year-old female. She was born and raised in Australia by parents of Palestinian origin. Layla achieved a post-graduate qualification and at the time of the interview she was employed full-time in a professional capacity. She was married with two children. Layla reported experiencing symptoms of anxiety and depression during her treatment for cancer and had accessed telephone counselling services at 26 years of age.

Participant 8: Rana

Rana is a 40-year-old female. She was born and raised in Australia by parents of Lebanese origin. Her highest level of education was a secondary school certificate. At the time of the interview she was self-employed and married with two children. Rana reported experiencing anxiety at 38 years of age and had engaged in professional counselling treatment with a Muslim psychologist.

Participant 9: Amira

Amira is a 24-year-old female. She was born and raised in Australia by parents of Palestinian origin. She had attained a post-graduate qualification and at the time of the

interview she was engaged in home duties. She was married with one child. Amira reported experiencing anxiety and depression at 22 years of age and had engaged in professional counselling treatment with a Muslim psychologist.

Participant 10: Zaid

Zaid is a 22-year-old male. He was born and raised in Australia by parents of Lebanese origin. At the time of the interview he was single, studying at university and was living at home with his parents. Zaid had no prior personal experience with mental illness or professional treatment services.

Participant 11: Ali

Ali is a 19-year-old male. He was born and raised in Australia by parents of Lebanese origin. At the time of the interview he was single, studying at university, and living at home with his parents. Ali reported no prior personal experience with mental illness or professional mental health services.

Participant 12: Marwan

Marwan is a 41-year-old male. He was born and raised in Egypt and migrated to Australia at 25 years of age. He completed his secondary schooling in Egypt and at the time of the interview was self-employed. He was married with one child. Marwan reported that he experienced depression from the age of 39 years but has no prior experience with professional mental health treatment services.

Participant 13: Sameera

Sameera is a 45-year-old female. She was born and raised in Eritrea and migrated to Australia as a teenager. She attained post-graduate qualifications and was employed part-time in a professional capacity. She was married with two children. Sameera reported

experiencing perinatal depression at the age of 38 years and had engaged in counselling treatment with a Muslim psychologist.

Participant 14: Amir

Amir is a 52-year-old male. He was born and raised in Egypt and migrated to Australia at 32 years of age. He attained post-graduate qualifications and was employed in part-time work. Amir reported no prior personal experience with mental illness or professional mental health services.

Participant 15: Imran

Imran is a 38-year-old male. He was born and raised in Pakistan and migrated to Australia at 25 years of age. At the time of the interview he was employed and married. Imran reported experiencing depression at the age of 36 years and had engaged in professional mental health treatment.

Participant 16: Adnan

Adnan is a 23-year-old male. He was born and raised in Australia by parents of Chinese origin. He converted to Islam at 19 years. At the time of the interview he had attained a bachelor degree and was employed in a professional capacity. He was married with one child. Adnan reported no prior personal experience with mental illness or professional mental health services.

Participant 17: Bilal

Bilal is a 35-year-old male. He was born and raised in Australia by parents of Lebanese origin. His highest level of education was a secondary school certificate. At the time of the interview he was self-employed and married with four children. Bilal reported no prior personal experience with mental illness or professional mental health services.

Participant 18: Hidaya

Hidaya is 22-year-old female. She was born and raised in Australia by parents of Pakistani origin. At the time of the interview she was studying at university, single and living with her parents. Hidaya reported no prior personal experience with mental illness or professional mental health services.

Participant 19: Mahmoud

Mahmoud is a 24-year-old male. He was born and raised in Australia by parents of Turkish origin. At the time of the interview he was studying at university, single, and living with his parents. Mahmoud reported no prior personal experience with mental illness or mental health services.

Participant 20: Umar

Umar is 48-year-old male. He was born and raised in Senegal and migrated to Australia at age 26. He competed his secondary schooling in Senegal and at the time of the interview he was self-employed. He was married with four children and reported no prior personal experience with mental illness or professional mental health services.

Interview procedure. The interviews were conducted in a range of settings which were selected on the basis of convenience and comfort for the participants. These settings were in participants' homes (n =12), in an office at the participants' place of work (n =5), in a café (n = 2) and in an Islamic centre (n = 1). In all settings, the interviews were conducted either in a separate room or in an area away from others for privacy. The duration of each interview was approximately one hour. Prior to commencing the interview, participants were engaged in small talk, which is a useful strategy to put participants at ease (Bogan & Biklen, 2007). The background and purpose of the research was explained and participants were informed that honest and open opinions were being sought and that there were no *right* or

wrong responses. Participants were assured of their confidentiality and that no obvious identifying information would be included in the final write-up. The participants were provided with written information regarding the project which detailed the aims and nature of the research (see Appendix A). This included the ethics approval number, relevant information about the researcher and the voluntary and confidential nature of the study. The participants signed consent forms before commencing the interviews (see Appendix B & C).

Interview questions. Initially, a range of questions were formulated to guide the interviews. These questions were designed to prompt discussion and facilitate reflections from the participants regarding their perspectives on and experiences of mental health and illness, and use of treatment services (see Table 4.1). These questions were formulated through consultation with stakeholders within the Muslim community who provided feedback on the wording and content. The interview schedule was used in a flexible way, allowing the participants to direct the course of the interaction. That is, during the interviews, participants tended to raise experiences or issues which they considered to be important and they were encouraged to elaborate.

Table 4.1. Broad areas of inquiry and corresponding interview questions

Broad area of inquiry	Interview questions and probes
Perceptions of services	To what extent do you consider that mental health services can be beneficial for Muslim clients?
Experiences with services	What are your experiences with mental health services?
Needs within the Muslim community	In your opinion, what are the mental health needs within the Muslim community?
Meeting the needs of the Muslim community	What are the issues that a provider would need to be aware of when treating Muslim clients?
Barriers	What are the barriers or concerns in accessing mental health services both for you and in the Muslim community?
Role of religion	To what extent do your religious beliefs shape your perspectives on mental illness? To what extent does religion have a role in maintaining your mental health and wellbeing? What role does religion have in responding to mental health problems?

Before seeking information about attitudes and experiences, the participants were asked demographic questions, such as their age, education level, current profession, ethnicity, marital status and place of birth. They were also asked whether they considered themselves to be "practising" Muslims.

The interviews were recorded with a small, portable audio recording device. As soon as feasible following the completion of the interview, the audio data were transferred to a compact disc and transcribed by a professional transcription service. The timely transcription and analysis of the interviews was done to assist the researcher to remain as close as possible to the data and the emerging concepts (Charmaz, 2006). The interviews were analysed by hand on a hard-copy document. Throughout the course of the research, the hardcopy data were stored in a locked cabinet and computer files were stored on a password protected hard drive to ensure that security was maintained.

Conducting Research in Indonesia and Jordan

Indonesia: Background information. Indonesia is a South-East Asian nation consisting of over 17,000 islands. The nation has a population estimated to be over 250 million and is the world's fourth most populous nation. Approximately 90% of Indonesia's citizens are Muslim (Cumming & Etchart, 2009). The official language is Indonesian, otherwise known as *Bahasa Indonesia*. The country is democratic, however, in some areas Islamic law has been introduced. Religion is integrated throughout many aspects of daily life and is intertwined with secular activities (Woodward, 2011). Islam is commonly practiced in Indonesia in a form similar to that in many regions of the world and is based on adherence to the five pillars of Islam. There is an obvious influence of Islam throughout Indonesia, such as an abundance of mosques, five-daily calls to prayer, Islamic dress and the widespread observance of religious events such as the fasting month of Ramadan and the Eid festivals (Rakhmani, 2016).

Indonesia was a colony of the Netherlands for more than 360 years until independence was attained after World War II in 1946. Mental health services were introduced under Dutch colonial rule in 1882 following the introduction of the Mental Health Act (Salan & Maretzki, 1983). This resulted in the establishment of Indonesia's first mental health hospital in Bogor, and other hospitals subsequently opened in East, Central and West Java, Sumatra, Kalimantan and Sulawesi. Mental health services of the colonial Dutch government were structured around the mental hospital, which primarily operated on a custodial approach to patient care and therapy (Salan & Maretzki, 1983). Indonesians were commonly admitted to hospital through a court order, and for the seriously ill, this often meant a life-time stay (Pols, 2006). During the Japanese occupation in World War II, the buildings of many mental hospitals were used for military purposes and others were severely damaged. Following the war, the provision of mental health treatment was limited, and in the

1950s and 1960s Indonesian mental hospitals only provided custodial care (Pols, 2006). Despite progressive developments in the mental health care system in the 1970s and 1980s, a reduction in funding for mental health resulted in a decline of services (Tampubolon & Hanandita, 2014). At present, custodial treatments continue to dominate in psychiatric hospitals and the public health care system provides only a basic level of care in Indonesia (Pols, 2006). The majority of people in the poorer rural districts have no access to professional treatment. Private mental health services are limited, and the rising numbers of Indonesians living in poverty in recent decades has meant that most are unable to afford mental health treatment (Tampubolon & Hanandita, 2014).

The region of Bogor in the West Java province of Indonesia was selected as a location for the research. As approximately 95% identify as Sunni Muslims (Cumming & Etchart, 2009) this provided a region which is majority-Muslim. Indonesia has rich cultural traditions and therefore the setting is culturally distinct from that of Australia and Jordan. This allowed for the examination of themes across distinctly different cultural and geographic groups.

Jordan: Background information. Jordan is an Arab kingdom in the Middle East and is officially known as the Hashemite Kingdom of Jordan. The country is located on the East Bank of the Jordan River and shares borders with Saudi Arabia to the south and east, Iraq to the north-east, Syria to the south and east and Palestine to the west. Jordan's population is approximately 8 million and the official language is Arabic. The country's official religion is Islam and Muslims make up approximately 92% of the population (Pew Research Center, 2012). The country is governed by a limited constitutional monarchy and the judicial system includes both religious and civil courts (Al-Sharari & AlKatib, 2015). The jurisdiction of the religious court extends over personal matters, whereas the civil courts have authority over all other aspects. Similar to Indonesia, there is an obvious presence of Islamic practice in daily life throughout Jordan, such as numerous mosques, five-daily calls

to prayer, observance of Islamic dress and participation in religious practices such as the fasting month of Ramadan and the Eid festivals.

The provision of mental health services has historically been limited in Jordan and there has been no mental health legislation in the country (WHO, 2011). The human resources for mental health for both the public and private sectors are unknown, however, estimates reveal that the number of mental health professionals per capita are relatively low. There is a lack of mental health training for primary health care workers, and interactions between the primary care and mental health systems are limited (WHO, 2011). Human resources for mental health are unevenly distributed with a large proportion of mental health professionals working in mental hospitals near the capital city, where only 36% of the population live. Meanwhile, political instability and conflict in nearby countries in recent decades has been a source of mental ill-health for both Jordanians and non-Jordanians. Jordan's location close to Palestine, Lebanon, Iraq and Syria has made it a recipient of refugees from several humanitarian emergencies and conflicts (Hijiawi et al., 2013).

There have been several developments in recent years aimed at addressing the shortage of mental health service provision in Jordan. Jordan was chosen as the first among six countries to implement the World Health Organization's Mental Health Gap Action Program in 2010 (Hijiawi et al., 2013). The program aimed to increase services provided in primary health care facilities for those suffering from mental disorders. At the secondary level of care, community mental health centres have been established, with training programs provided for general health care practitioners (WHO, 2011).

Similar to Indonesia, as a majority-Muslim country Jordan provided an important contrast to Australia. In addition, as an Arab country, Jordan has rich cultural traditions which are distinct from both Indonesia and Australia. This allowed for an examination of

themes across diverse settings. Finally, Jordan is one of the most politically stable nations in the region, making this location an appropriate choice for research in an Arab country.

Participant Recruitment and Data Collection Procedure

Participants. Similar to Australia, for the Indonesian and Jordanian samples, the researcher sought participants who were at least 18 years of age, were born and raised in the community, and considered themselves to be practising Muslims. Recruitment of participants was through word of mouth in their communities. This continued until interviews had been conducted with participants who represented a range of educational and professional backgrounds.

The same procedure as in Australia was followed in terms of providing participants with information about the study and obtaining their consent. The same approach was also followed regarding the interviews with recordings being made on an audio recording device. As in Australia, the duration of each interview was approximately one hour.

Interviews in Indonesia. The interviews in Indonesia were undertaken in Bogor in 2010 and 2012. Bogor is located in the West Java province, approximately 60 kilometres south of the capital city Jakarta. Bogor is a well-established region with over 95% of its population being Muslim (Hellwig, & Tagliacozzo, 2009). In order to recruit participants in Indonesia, I contacted a principal at a suburban school in Bogor. The principal held a trusted and respected position in the community and so was able to connect me with the local community.

Eight individuals volunteered to participate with ages ranging from 25 to 43 years (M = 33.63, SD = 5.68), and an equal number of males and females. Prior to undertaking the interviews, participants were asked a range of demographic questions, including their place of birth, where they were raised, their level of education, profession and marital status. They

were also asked whether they considered themselves to be "practising" Muslims. Seven of the interviews were conducted in English. One participant, Hani, understood spoken English, however, she indicated that she did not feel confident to engage in the interview in a second language. Hani nominated an acquaintance to translate for her. There are limitations in utilising a translator as the participant may be less inclined to be open about their experiences if there is another person present (Temple & Young, 2004). Hani noted that she was comfortable with this person and had no reservations about her attending the interview. The interviews were carried out in locations nominated by respondents across Bogor, which were either their home (n = 4) or place of work (n = 4).

Indonesian Participants: Pseudonyms and Descriptions

Indonesian Participant 1: Anas

Anas is a 33-year-old single male. He was born and raised in Bogor. He completed secondary schooling in Indonesia and was working in an unskilled profession. Anas reported no prior personal history of mental health problems and no experience with professional mental health services.

Indonesian Participant 2: Fitri

Fitri is a 27-year-old married female. She was born and raised in the Bogor region. She completed her university education in Jakarta and was working in a professional role in Bogor. She reported no prior personal history of mental health problems nor experience with professional mental health services.

Indonesian Participant 3: Nisa

Nisa is a 37-year-old single female. She was born and raised in the Bogor region. She had completed her secondary education in Indonesia and worked full time in a semi-

skilled role. Nisa reported no prior personal experience with mental health problems or professional treatment services.

Indonesian Participant 4: Fatah

Fatah is a 36-year-old married male. He was born, raised and completed his university education in Jakarta. At the time of the interview, Fatah was working professionally in a full-time role in Jakarta. He reported no personal experience with mental health problems or professional treatment services.

Indonesian Participant 5: Rahmat

Rahmat is a 35-year-old married male. He was born and raised in Jakarta and completed university studies in Jakarta. At the time of the interview, he was employed in a professional role in the Bogor region. Rahmat reported no prior personal experience with mental health problems or professional treatment services.

Indonesian Participant 6: Dina

Dina is a 43-year-old married female. She was born and raised in the Bogor region. She completed her secondary schooling in Indonesia and at the time of the interview she was engaged in home duties. She reported struggling with depressive symptoms due to the stress of caring for her son, who had been diagnosed with Autism Spectrum Disorder. She accessed psychological treatment for her son, however, she had not sought professional treatment for herself.

Indonesian Participant 7: Rafi

Rafi is a 25-year-old single male. He was born in Jakarta and grew up in a suburb East of Jakarta. He completed post-graduate qualifications and worked full-time in a

professional role. He reported no prior personal experience with mental health difficulties or professional mental health services.

Indonesian Participant 8: Hani

Hani is a 33-year-old widowed female with three children. Hani was born and raised in the Bogor region. She completed her undergraduate study in Jakarta and was working in a professional role in Bogor. She reported suffering from depressive symptoms following the death of her husband, however, she had not accessed professional mental health treatment.

Interviews in Jordan. The interviews in Jordan were undertaken in the capital city, Amman, in 2015. Amman is the most populous city of Jordan and a major cultural, economic and tourist centre in the Arab world (Alnsour, 2016). In order to recruit participants, contact was made with a department coordinator at a learning institute in Amman. Similar to Indonesia, collaborating with a trusted contact was essential in order to provide a bridge with the local community. In addition to providing a gateway to potential participants, the local contact was a source of knowledge and information in regard to conducting culturally sensitive research. The department coordinator provided opportunities to meet with locals in the community in order to explain the research and extend an invitation for volunteers. Six volunteered to participate, with an equal number of males and females. The interviews were conducted in locations nominated by the participants, all of which were at their places of work. Similar to Indonesia, efforts were made to build rapport with the participants prior to conducting the interviews. Five of the interviews were conducted in English. One participant, Aseel, nominated a translator who was proficient in both English and Arabic. The ages of the participants ranged from 23 to 38 years (M = 30.67, SD = 5.20).

Jordanian Participants: Pseudonyms and Descriptions

Jordanian Participant 1: Amal

Amal is a 28-year-old single female. She was born and raised in Amman. She completed her undergraduate study in Amman and undertook her post-graduate studies in the United States. At the time of the interview she was working in a full-time professional role in Amman and was living at home with her parents. Amal reported no previous personal history with mental health problems or treatment.

Jordanian Participant 2: Aseel

Aseel is a 34-year-old married female. She was born and raised in Amman where she completed her primary and secondary schooling. At the time of the interview she was engaged in home duties. Aseel reported no personal history with mental health problems or treatment.

Jordanian Participant 3: Nur

Nur is a 23-year-old single female. She was born and raised in a village outside of Amman. She completed her undergraduate studies in Amman. At the time of the interview, Nur was working full-time in a professional role in Amman and living with friends in share accommodation. She reported experiencing difficulties focusing on her studies in secondary school and had sought spiritual healing through a local religious leader.

Jordanian Participant 4: Diyaa

Diyaa is a 29-year-old married male. He was born and raised in a village outside of Amman. He completed his secondary schooling in Jordan. When interviewed he was working full-time and living with his wife and three children. He reported no personal mental health problems and had not previously accessed mental health treatment.

Jordanian Participant 5: Lina

Lina is a 38-year-old married female. She was born and raised in Amman where she completed her tertiary studies. At the time of the interview she was working in a full-time professional capacity and living with her husband in Amman. She reported no previous personal history with mental health problems or treatment.

Jordanian Participant 6: Maha

Maha is a 32-year-old divorced female. She was born in Kuwait and raised in Amman. She completed her undergraduate and postgraduate degree in Amman. At the time of the interview she was working in a full-time professional capacity in Amman. She reported experiencing depressive symptoms following the breakdown of her marriage. She had accessed professional counselling, but had discontinued after a short period of treatment due to the financial cost.

Online Survey: Development and Procedure

An online survey was used to target a broader sample of Australian Muslims. An advantage of such a survey is that it lacked social pressure which could have assisted respondents to provide truthful answers to sensitive questions (Ornstein, 2013). In addition, unlike the interviews the self-administered nature of the survey allowed the participants to set their own pace in responding to items. The survey was designed to extend the qualitative data by further exploring themes which emerged from the face-to-face interviews. This was intended to gauge the participants' perspectives, responses and attitudes relating to specific ideas and experiences. As such, the individual items were the focus of analysis. The space for comments following each item allowed for written reflections from respondents, which provided additional qualitative data for the development of concepts.

Survey development and structure. Initially, participants were asked to complete a series of demographic items. Specifically, these concerned their age, gender, education level, place of birth, cultural background, whether they considered themselves to be practising Muslims, whether they were Australian citizens / permanent residents, and whether they were converted or born Muslim.

Following this, the participants completed the *Muslim Mental Health Survey*. As no existing measure was available, the I as the researcher developed this survey for the purposes of the research. The data from the face-to-face interviews with participants in Australia was used to guide the development of the items. This is consistent with *theoretical sampling* as described by Glaser and Strauss (1967) which entails collecting data in order to further develop categories which contribute to the emerging theory. The early analysis of the face-to-face interviews revealed six categories. These were prior experiences with services, views of counselling, views of services for Muslims, Muslims' knowledge of and attitudes toward mental health, the role of community and religious support, and barriers to accessing services. Each of these areas were developed to explore the main issues and concerns that were emerging through the face-to-face interviews. Table 4.2 presents the identified categories and the associated survey items.

As indicated in Table 4.2, in exploring the six categories the final survey included 28 items. Some items (4) required either a Yes/No response, selection from a list of forced-choice options or an open-ended response. The majority of the items (24) were phrased as statements to gauge attitudes. These included the same 4-point Likert scale response options; 1=*Strongly Agree*, 2=*Agree*, 3=*Disagree*, and 4=*Strongly Disagree*. These options were used to ensure consistency in response format throughout the survey (Groves, et al., 2009; Krosnick & Presser, 2010). It was decided not to include a neutral option, such as *no opinion* or *don't know*, and instead to require the respondents to choose a stance on each statement

(Rea & Parker, 2014). According to Krosnick and Presser (2010), neutral responses often do not reflect a genuine lack of opinion, but rather indicate ambivalence or self-protection. Furthermore, the exclusion of a neutral option is advisable when it is suspected that it will be selected by a large number of respondents (Ornstein, 2013). During the face-to-face interviews, the participants were at times reluctant to give a definite stance and qualified that their views were dependent upon the details of a given situation. For example, participants explained that seeking help from religious leaders would depend upon the issue for which help was being sought and whether religious knowledge was relevant for their particular concerns. Given that a neutral option was not provided, the survey included "comments boxes" to accompany most of the items to enable respondents to provide further information about their opinions (Krosnick & Presser, 2010; Orntein, 2013).

Table 4.2. Muslim Mental Health Survey: Identified categories, corresponding items and response format

Category	Survey Items	Response Format
Prior experiences with Services	Have you accessed services with a counsellor, psychologist, or other mental health professional?	Yes/No
	Have you accessed counselling with a Muslim counsellor / psychologist?	Yes/No
Views of counselling	Counselling / psychological services can be beneficial for Muslims	Likert Scale
	It would make no difference to me whether a counsellor / psychologist is a Muslim or non-Muslim	Likert Scale
	I would only seek services from a counsellor / psychologist if he/she were Muslim	Likert Scale
	It is important to combine the spiritual and religious teaching of Islam with counselling treatment	Likert Scale
	It is not appropriate for Muslims to seek help from counsellors / psychologists	Likert Scale
	Muslims should try to deal with their problems within their own community without seeking help from counsellors / psychologists	Likert Scale
Services for Muslims	It is important that non-Muslim counsellors/psychologists have some understanding of Islam when treating Muslim clients	Likert Scale
	Counsellors / psychologists can provide effective services to Muslims through training about Muslims and the Islamic faith	Likert Scale
	Non-Muslim counsellors / psychologists cannot understand emotional / psychological problems from a Muslim's perspective	Likert Scale
	I believe that non-Muslim counsellors / psychologists may have biased or stereotypical attitudes towards Muslims	Likert Scale
	I believe that non-Muslim counsellors / psychologists may	Likert Scale

	encourage Muslim clients to solutions that are against Islam	
	I would be concerned about confidentiality with a Muslim counsellor / psychologist	Likert Scale
	What are the issues you would like your counsellor / psychologist to be aware of regarding your faith as a Muslim?	Open Response
Muslims and Mental Health	Most mental health problems are caused by jinn or other unseen forces	Likert Scale
	I believe that Muslim who need counselling / psychological services have a weakness in their faith	Likert Scale
	Mental health problems are usually caused by a weakness in faith	Likert Scale
	Which of the following mental health conditions have you suffered? (Depression, Anxiety, Bipolar Disorder, Psychotic Disorders, Other)	Check Box
Community and religious support	There are not enough qualified Muslim counsellors / psychologists to assist the Muslim community	Likert Scale
	The Muslim community needs more mental health support services	Likert Scale
	The imams in the Muslim community have a good understanding of mental health problems and treatment	Likert Scale
	If a Muslim is suffering from emotional / psychological problems he / she should seek advice from a local imam before seeking other services	Likert Scale
	The Muslim community needs more information and education about mental health problems and available services	Likert Scale
	Islam is important for my emotional / psychological wellbeing	Likert Scale
Accessing Services	I would feel embarrassed to access services with a counsellor / psychologist	Likert Scale
	Most of my family members would be embarrassed to discuss their mental health problems with a counsellor / psychologist	Likert Scale
	My family would approve of me accessing services with a counsellor / psychologist	Likert Scale

Procedure. The survey was piloted with five Australian Muslims. Pilot testing new surveys is necessary in order to ensure that questions are clear and identify items which reflect researcher bias (Punch, 2003). A number of changes were made based upon the feedback, predominantly related to expressing the items more clearly. Once finalised, the survey was uploaded on the *PscyhData Surveys* website and was available from January to December 2013.

An introductory statement was provided to explain the nature and purpose of the study (see Appendix D). This emphasised that the responses were anonymous and that the confidentiality of the respondents was assured. This was highlighted to allay possible

concerns regarding the security of personal disclosures. The introductory statement noted that the researcher was a PhD candidate at Australian Catholic University and included ethics approval details. It indicated that there were no right or wrong answers, but rather honest views and opinions were being sought. In addition, the introductory statement was expressed in such a way as to gain the cooperation of the respondents (Punch, 2003). Muslims may have reservations about participating in research due to concerns about the researchers' intentions or fears that the outcomes will have adverse consequences for their community. Therefore, the statement opened with the Islamic *Assalamwalikum* meaning "May peace be on you", which is a universal greeting used by Muslims. A comment was included noting that participation was valued and appreciated. The statement concluded with the researcher's name which was preceded with the title "Sr.", meaning "sister". Muslims in Western societies commonly refer to one another as "sister" or "brother", which connotes the notion of brotherhood based upon faith.

Participant Recruitment

Participants were recruited through the distribution of information fliers (see Appendix E). These were distributed at Islamic meetings and organisations in Melbourne, Perth and Sydney including an Islamic conference (n = 1), mosques (n = 4), Islamic study circle (n = 3) and Islamic community centres (n = 2). The information flier was also distributed electronically through two Australian Muslim email groups. The fliers invited respondents to participate in the survey and included information about the researcher, the aims and nature of the project, and provided a link to the survey.

Survey Participants

A total of 214 respondents completed the survey. Of these, 14 were excluded as they indicated that they were not practising Muslims.

Table 4.3. Survey participant characteristics (N = 200)

Demographics	*n* (%)
Participants' age in years	
18 - 29	106 (53.0%)
30 - 39	60 (30.0%)
40 - 49	18 (9.0%)
50 - 59	8 (4.0%)
60 - 69	4 (2.0%)
70 - 79	1 (0.5%)
80+	3 (1.5%)
Educational Attainment	
Secondary Schooling	18 (9.0%)
Certificate	14 (7.0%)
Diploma / Advanced Diploma	24 (12.0%)
Undergraduate / Bachelor Degree	90 (45.0%)
Postgraduate degree	47 (23.5%)
Other	7 (3.5%)
Country of Birth	
Born in Australia	94 (47.0%)
Born overseas	106 (53.0%)
Religion	
Born Muslim	164 (82.0%)
Converted to Islam	36 (18.0%)

Of the final sample, 49 were male and 151 were female. The demographic characteristics of the respondents are presented in Table 4.3. As indicated in Table 4.3 the majority of the participants (n = 166; 83%) were relatively young being aged under 40 years. Of note, the Australian Muslim population is significantly younger than the Australian population; over 80% are aged 44 and under (compared to just over 60% of non-Muslim Australians). Only 3.4% of the Australian Muslim population is aged 65 years and over (Hassan, 2015). Most of the participants had undertaken tertiary education (n = 137; 68.5%). This is higher than the level of educational attainment for Muslims in Australia generally; only 16.7% have attained a Bachelor or Postgraduate degree (Hassan, 2015). Although almost half of the participants were born in Australia, affiliations with over 75 different cultural backgrounds were identified, with representations from countries throughout the

world including from Africa, the Middle East, Asia and Europe. This cultural diversity is reflective of national data (ABS, 2016).

Data analysis: Interview Transcripts and Survey Data

As noted, grounded theory methodology was used to analyse the qualitative data including that from the interviews and the further comments offered in the online survey. To begin with, the interview transcripts and questionnaire comments were printed on a hard-copy document. These were then analysed by hand.

The data analysis was undertaken in three main steps consisting of initial coding, focused coding and theoretical coding. This process was not conducted in distinct stages, rather it involved moving back and forth between the data and the analysis in order to identify relationships between concepts. Although the data were fragmented for analysis in the coding process, ultimately the interpretation aimed to keep the broader picture of the data body in mind. The process of data collection and analysis is depicted in Figure 4.1.

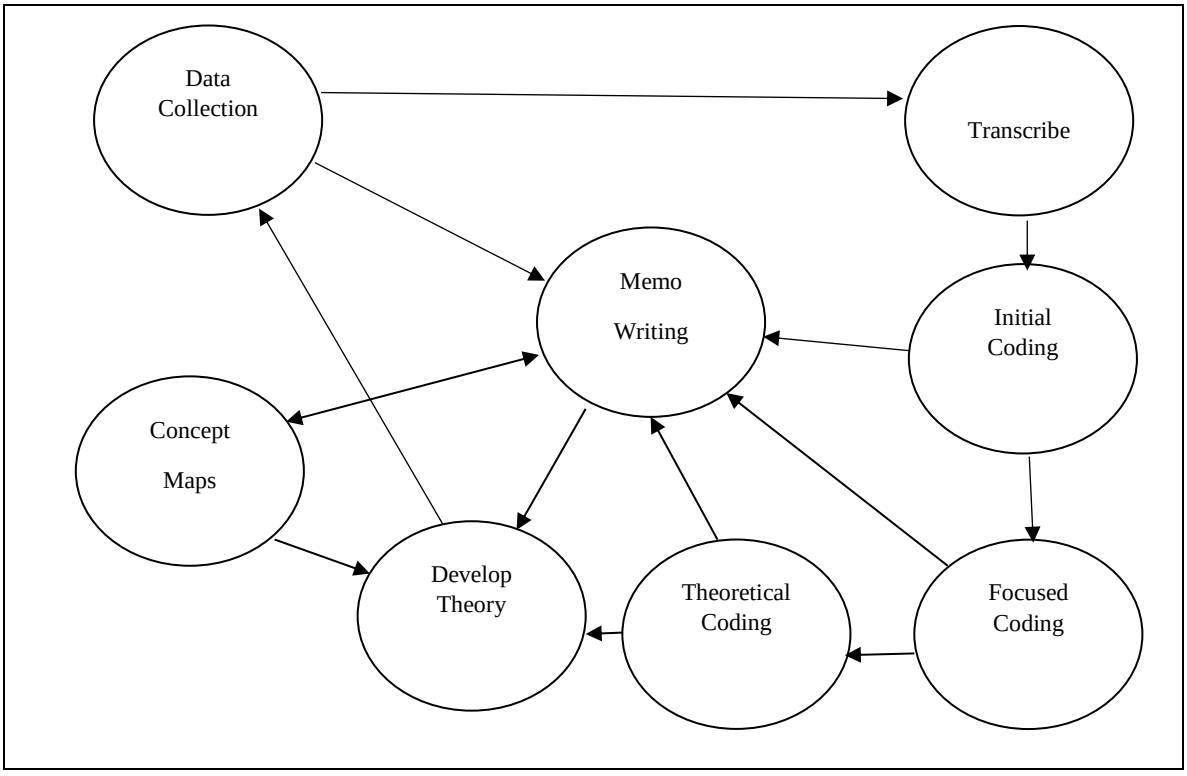

Figure 4.1. Process of data collection and analysis

Step 1: Initial coding. Once the first two interviews were completed and transcribed, *initial coding* commenced. From this point, data collection and analysis were conducted in parallel as advocated in classic grounded theory (Glaser, 1978; Glaser & Strauss, 1967). This timely and synchronous process aimed to maintain a close connection with the raw data so that emerging themes could be discovered and potential areas for further enquiry identified (Birks & Mills, 2015).

Coding the raw data was the first step in discovering key themes as this builds an understanding of patterns or processes grounded within the data (Charmaz, 2006). The coding involved reviewing the interview transcripts line-by-line to identify what was happening in small segments of data, as the example shows in Figure 4.2. As the raw data were examined, labels were given in short, simple, active terms to identify the main concepts and themes. This process involved self-reflection and self-interrogation about the early analytical decisions that were made. Coding in this way assisted in stepping away from assumptions and pre-conceived ideas in order to tune in to the participants' worldviews and see their experiences through their eyes (Charmaz, 2000).

Initial Narrative Data to Be Coded	**Examples of codes**
(Mahmoud) Each case is different. When you look at for example, trauma, you know, all these things, anxiety, look Islamically we have always said, you know, we need to put our trust in Allah and, you know, every sheikh would say to you, you know, you have to go back to Allah and do all this, that's fair enough, but at the same time each case is different. I really believe if it's something that's getting out of hand then they need to seek someone of professional nature to see what happens. Again, it just comes down to the severity of the actual case itself, some people are very severe who, um, if we're talking about, you know, people we believe have *jinns* for example, I believe they need	Seeing each case as unique; different needs Emphasis on Islamic perspectives - trusting in Allah Consulting with religious leader Islamic advice - turning to Islam Consider the treatment needed depending upon each case Open to seeking professional help - (severe cases) Belief in the role of the supernatural phenomena in mental illness Seeing the role of religious leaders in

to go see a sheik and deal with this. If it's something that he can't deal with then it could be something else, it all comes down to I'm not sure, depending on each case, each case is different. Anxiety, obviously it's a widespread thing at the moment and people taking pills, people doing this, you know, I mean could work for some people, doesn't work for others, at the end of the day it's what works best for you.	accessing treatment Importance of understanding the needs of each case Acknowledgement of mental illness (anxiety) Medication - role in treating mental illness Seeing different treatments for different cases

Figure 4.2. Example of initial coding

During the initial coding process, a number of questions were posed, such as "What is happening here?" (Glaser, 1978), "What is this data revealing?", "What does the data suggest?", "From whose point of view?", "What category does this specific datum indicate?" (Charmaz, 2000; 2006). This process was useful not only for the initial generation of codes, but also to identify gaps in the data, which required further inquiry. This helped to focus the investigation as data collection progressed. For example, in the early interviews, the concept of combining religious and secular approaches to the treatment of mental illness was identified, and as such, this was further explored in subsequent interviews and the online survey. During initial coding, the data were examined without limitations in its scope, and therefore all data were accepted and none were excluded (see Figure 4.2).

Step 2: Focused coding. As line-by-line coding progressed, codes were identified which were recurring or that helped to explain larger portions of data. These codes were deemed to be *focused codes* and were more selective than the initial line-by-line coding (Charmaz, 2006; Glaser, 1978). The stage of focused coding involved identifying codes that appeared to go with other codes. This process required decisions to be made regarding which codes provided a way to categorise larger portions of data. Focus codes were considered to be *saturated* when fresh data no longer provided new insights. An example of a focused code is *Turning to Religious Coping,* such as turning to prayer, reading the Quran, making supplications (*du'a*), remembrance of God (*dkihr*) and spiritual healing practices. *Turning to*

Religious Coping was part of the participants' process in responding to difficulties and was a first step before seeking help. This label helped to identify larger portions of data across the various samples. As such, focused codes were identified through comparing data with data, then comparing data with codes, and then codes with codes (Charmaz, 2006).

Step 3: Theoretical coding. The final stage involved analysing the connections and relationships between the focused codes and integrating these to represent the findings (Charmaz, 2006). The aim of this stage of the analysis was to develop clarity in the explanation of the data as a whole. For example, the concept of the *Sacred Compass* subsumed a number of other concepts, such as *Religious Coping* and *Directing Choices and Behaviours*. Theoretical codes provided structure and meaning to the focused codes. In this way, the theoretical codes helped to explain the data in a way that had meaning and coherence. At this stage of analysis, a basic pattern or process was identified to provide a theoretical explanation of the data.

Grounded Theory Techniques

Constant comparison. A core component of grounded theory methodology is constant comparative analysis (Strauss & Corbin, 1998). This was employed throughout the analytic process and involved comparing codes and concepts found within the data (Ezzy, 2002; Strauss & Corbin, 1998). This process provided a way to compare the data with data, codes with codes, and concepts with concepts, and therefore was a useful way to reveal similarities, differences, and patterns within the data. In applying constant comparison, I continually returned to the data, and compared the incidents to other incidents to identify similarities and variance. According to Strauss and Corbin (1998), constant comparison strengthens the validity of the findings, as this strategy allows the concepts and categories to be identified across data obtained from the different sources.

Memo writing. Throughout the data analysis extended notes, or *memos* (Charmaz, 2006; Strauss, 1987), were written to explore and analyse the codes and categories (see Figure 4.3). Memos provided the intermediate stage between coding and writing a draft chapter (Charmaz, 2000). Raw data were included in the memos to maintain the connection with the data. This intermediate writing stage was helpful in maintaining engagement in the analysis and elaborating upon themes and concepts as they emerged. Memos helped to catch thoughts, ideas, insights and connections between concepts as they arose. Memo writing was useful as it enabled the continued analysis of the emerging categories and helped to identify incomplete categories. This process pointed to areas where further research was needed to explore and elaborate upon the categories. As the categories were further identified and defined, they were linked and integrated. Through the development of these memos, the concepts became more focused and they formed the basis for the write-up of the findings.

Perspectives of mental illness - accommodating religious and secular perspectives

Participants discussed their perceptions of mental health and illness in different ways, and their views tended to provide a picture of complex causes of mental illness, including biological, social and psychological causes. These conceptions are common in Western, mainstream conceptualisations. However, these same participants also made references to religious and spiritual perspectives, referring to mental health problems being caused by a lack of faith, weakness in their spiritual connections and religious practices, and also made reference to supernatural phenomena, such as jinn, black magic, and the evil eye. These perspectives appear to be divergent, however the participants themselves seemed to see no conflict between these differing views and appeared to be able to accommodate both perspectives in the views.

Figure 4.3. Example of an early memo

Concept maps. In order to aid the analysis and writing process, themes and concepts were continually mapped out (see Figure 4.4). The process of *concept mapping* provided a visual representation to organise and understand the data (Clarke, 2003, 2005). The mapping of concepts helped to provide clarity in identifying key concepts, and representing the ways in which concepts were connected and related to one another. This is consistent with the practices of prominent theorists (e.g., Clarke, 2003, 2005; Strauss, 1987; Strauss & Corbin,

1998) who consider that developing visual representations of their emerging theories is a fundamental aspect of grounded theory strategies. In the present research, concept maps were continually developed and reviewed throughout the data collection and analysis process to check for clarity and comprehensiveness in representing the participant views and experiences. These diagrams assisted in organising the main concepts and checking for their coherency. The concept maps provided the basis for organising the structure of the findings and also for the final models to explain the findings.

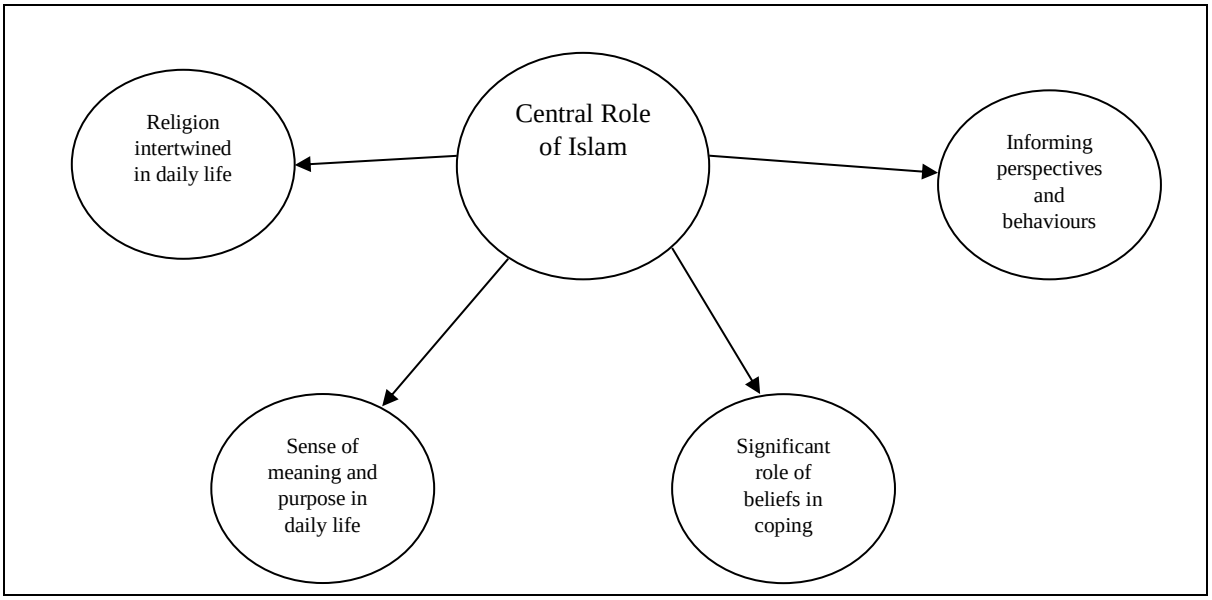

Figure 4.4. Example of early concept map

Survey data analysis. The quantitative data from the survey were entered into an Excel spreadsheet and then imported into the statistical analysis software SPSS (Statistical Package for Social Scientists). The benefit of Excel was that there are no character limits for variables, which was useful for the open question comments. The data were analysed in terms of frequencies and percentages of responses for each survey item. This provided a way to determine whether the views expressed by the interview participants were evident in a larger sample of Muslim participants. A similar approach to analysing survey responses was performed by Dunn et al. (2015) in investigating the attitudes and experiences of Muslims living in Australia. This provided a coherent picture of their views covering a range of areas.

The survey items which were relevant to the main identified concepts across the data samples were included in the reporting of the findings. As noted, the participant comments on the survey were added to the qualitative data and analysed accordingly.

Conclusion

This research sought to understand the perspectives and experiences of Muslims in relation to mental health and illness and its treatment. Due to this focus a predominantly qualitative approach was adopted. Grounded theory provided a set of structured, yet flexible processes for undertaking this endeavour. A constructivist paradigm was used throughout the data collection and analysis phases. This entailed approaching the research process with a perspective that seeks to understand the various realities of those involved. This approach was determined to be most appropriate as the research sought to draw conceptualisations inductively from the data. In order to gain an understanding as close as possible to the participants' meanings, the expressed perceptions and experiences of the participants, told through their own words, were placed at the centre of the analysis. The varied samples provided a diverse range of Muslims' perspectives and experiences. The survey provided quantitative and qualitative data with a larger sample of participants.

The following chapters will present the results of the research. The findings are presented in three chapters, each of which addresses a core theme identified in the data. The first of these chapters provides an exploration of the significance of Islam for Muslims in their daily lives. A framework is introduced which depicts the role of Islam for Muslims in conceptualising their mental health problems, and maintaining positive wellbeing and coping in times of adversity. This is followed by a chapter that addresses the help-seeking pathways of the participants. This includes an examination of the barriers and facilitators for accessing

mental health services. The final results chapter outlines the role of religion in treatment. Therefore, the next chapter is the first of three that present the research findings.

Chapter 5

Islam though the Eyes of Muslims

The literature review highlights the lack of research that investigates the perspectives and experiences of Muslims regarding their mental health from both majority-Muslim and Western liberal societies. As such, mental health practitioners may lack an accurate understanding of the needs of Muslim clients. The research aims to give voice to Muslim participants from a diverse range of sources in order to gain an understanding of their viewpoints and experiences. Specifically, this exploration seeks to illuminate the ways in which Islam influences the participants' conceptualisation of mental health and illness, impacts on their wellbeing and shapes their coping responses.

The findings included in this chapter are drawn from the face-to-face interviews conducted in Australia, Indonesia and Jordan, as well as the online survey data. The participants from the face-to-face interviews are referred to by pseudonyms. The comments of respondents from the online questionnaire are referred to by their number (e.g., Respondent 46).

Overall, this chapter highlights the significant role of Islam in the participants' lives, conceptualised as providing the dual functions of a *sacred lens* and *sacred compass.* The *lens* is described as shaping participants' perspectives and beliefs, whereas the *compass* directs and guides their choices and actions. The role of Islam for the participants is summarised in Figure 5.1 and the associated concepts are explained in detail throughout this chapter.

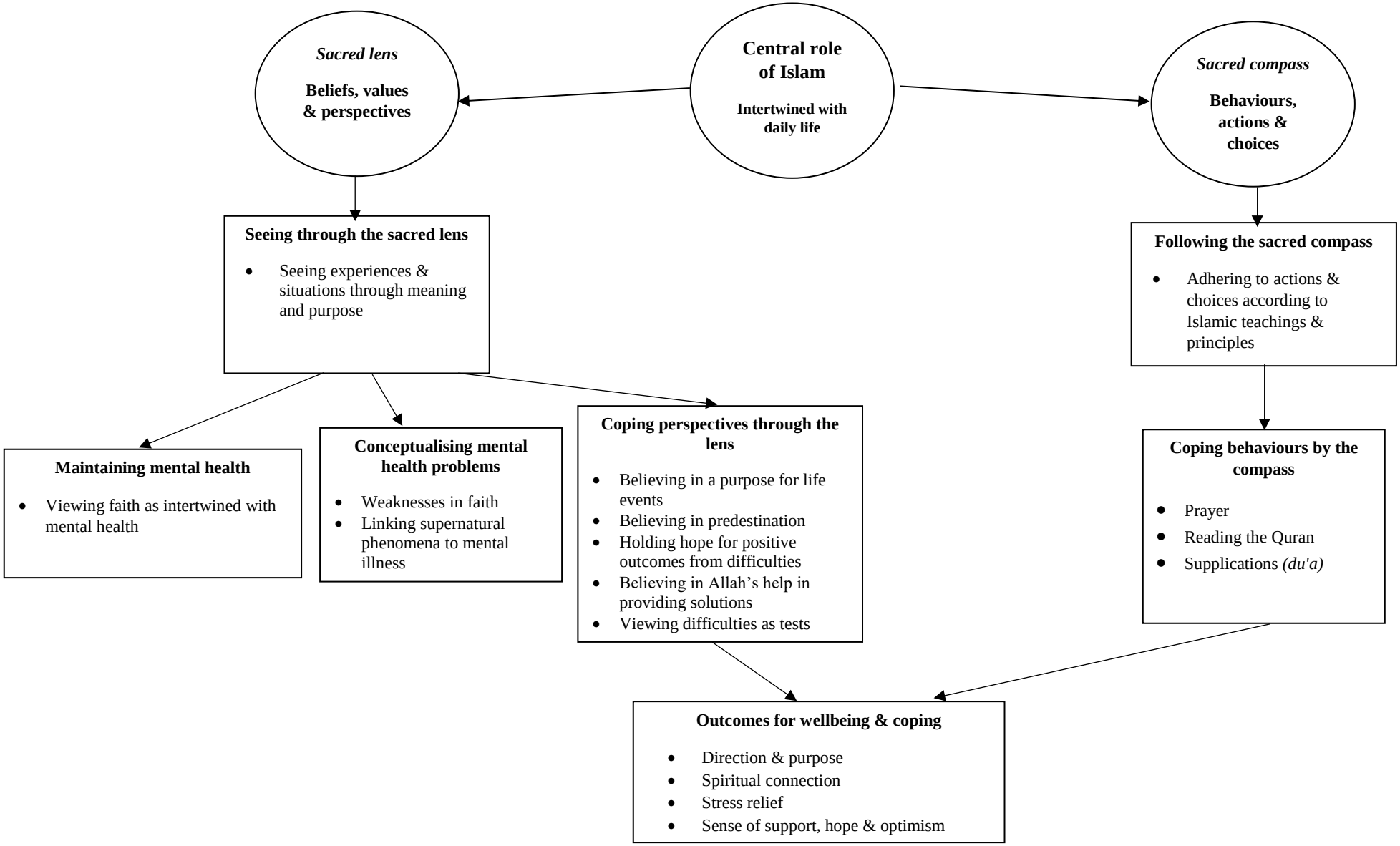

Figure 5.1. The role of Islam for Muslims in daily life and with mental health

The Central Role of Islam

Across the three countries, the participants' comments consistently revealed the deep significance of Islam in their lives (see Figure 5.1). Amir emphasised the importance of Islam stating, "[Islam] is a priority in my life." Hidaya described the profound role of Islam as being beyond "important". As she explained,

> I sometimes think if I didn't have Islam then I wouldn't have anything, like it just really guides me and helps me in every way ... even like now when I went to the library, I was studying, you know, I had mini breaks, my mini breaks were going to pray... so it's good ... I'm even more grateful to have Islam now than ever before ... it impacts my life in every aspect.

Hidaya's reflection signifies Islam as a constant and positive presence. Her comments show that Islam is intertwined even in the relatively mundane aspects of life. Other participants similarly provided a picture of daily life being merged with faith. For example, Australian participant Sameera stated, "Islam is a way of life, it's not only worship." She further explained,

> [Islam] ... without a doubt, gets me through every day. It is who I am. It's the first thing I think of when I wake up in the morning. It is what drives all my decisions, and this is even from a young age. Without Islam, I don't know how I would be. Even when I'm dealing with any person throughout my day, the religion is there. I'm always reminding myself, whoever it is ... Muslim, non-Muslim, I'm always smiling, I'm always polite, it always comes from my religion.

Mahmoud, also an Australian, commented on the role of Islam in providing guidance for his actions and choices, "From a Muslim's perspective, Islam is a way of life, it governs everything you do." Jordanian participant Lina extended this view by providing a description of Islam as being intertwined with her identity. She stated that,

> [Islam] is part of me so we can't separate this thing from me. So, in order to understand me, my condition, everything, like you have to take myself with everything, my thoughts, my beliefs, everything, because [Islam] absolutely has an effect on oneself.

Repeatedly, the participants pointed out that religious teachings provide guidance for all aspects of their day-to-day living, including their perspectives and responses to their

circumstances. This integration of Islam in daily life was represented by the participants throughout the data with descriptions such as a *way of life* and *holistic* way of living. This provided a picture of a comprehensive system integrated with all spheres of their lives. For example, in the survey, Respondent 140 wrote, "Islam is my way of life and is first and foremost for me. It's not just praying or fasting, it's my way of life." Also, Respondent 194 wrote, "Islam is a religion which gives you a way of life, everyday living. Teaches us how to respect, care, love, work and so on ... so it fits with every day of life." Other descriptors of Islam expressed by participants such as *guiding*, *shaping*, *directing*, and *governing* also suggest that the religion has a central influence on their decision making.

Rather than being static, the participants considered their practice of Islam to be an evolving process. They indicated that the integration of Islam in their lives developed through periods of reflection, personal growth and maturity. For example, Indonesian participant Rafi explained that he was raised in a Muslim household and a key part of maturing into adulthood was taking religion more seriously. Through this process he began incorporating religious guidance as a prominent feature of his life. Undertaking his tertiary studies abroad in Malaysia marked a time of deeper reflection regarding his religious identity and practice. He stated, "That's my turning point, I started to learn [about] Islam, I started to be more conscious about what I do, and I can say that I grew up at that time." For Rafi, increasing his knowledge was an essential part of this process. He further explained,

> In Malaysia ... everybody stops their thing and then they go to mosque. I learned how to pray on time, I learned that when we get closer to Allah, Allah will get even closer to us, more than we think. I didn't really socialise with others but I was focusing on [developing] myself there.

Rafi indicated that this period led to changes in his behaviours and choices. He stated,

> Before I learnt about Islam, I just live my life using general things. For example, if general people say that, for example having a beard is in style I'll do it, I don't think about Islam. But now, what Islam says is good I'll do that ... if we do something that

> we like but Allah doesn't like it it's going to be something like fighting in our heart, so I prefer doing something that Allah likes.

In this way, Rafi described how the practice of Islam developed to increase his consciousness of God in his everyday life. His comments highlight his contentment in choosing behaviours consistent with the religion. Like Rafi, Hani (an Indonesian), described her process of maturity and finding a deeper meaning in coping with problems through her faith. She stated,

> When I was a teenager I liked to read all the psychology books. But then when I face another bigger problem I'm not satisfied, I didn't find the answer in psychology and I was looking, searching, and I go around until I find the answer in religion.

Australian participant Bilal described the change in direction of his life when he became more committed to religion as an adult. He explained that,

> Eleven years ago, I wasn't practising [Islam] ... eleven years ago I wouldn't even know the *fatiha* [first chapter of the Quran] ... all I knew was how to party hard, go out, my life was only about living the day, as in living the life. Eleven years ago, until today my life completely changed, I've got direction ... now it's different for me and now I teach my children, you live for the *akhira* [the after-life] ... I've got a direction and goal to get to.

Bilal's comments reveal that Islam has helped him to shift his priorities to focus on a life purpose. Overall, the data revealed the significance of Islam in the participants' lives and this was reflected through their individual journeys. The integration of Islam in their day-to-day experience developed over time and provided them with deeper meaning through their efforts to attain closeness to God.

The *Sacred Lens* and the *Sacred Compass*

The function of Islam in the participants' lives occurred in two main ways (see Figure 5.1). The first was the function of the Islamic beliefs and faith teachings in shaping their cognitive responses. This was a *sacred lens* through which the participants viewed their world and understood their experiences. This *lens* was provided through the beliefs, values and perspectives contained in sacred texts of the Quran and the books of *hadeeth* [Prophetic traditions]. The second function of Islam was the way in which it guided and directed their

actions and choices. This was a *sacred compass* that the participants followed so that their responses and actions were aligned with Islamic teachings. This *compass* consists of the guidance and teachings pertaining to actions which are required or encouraged in Islam and the Islamic boundaries of behaviours and choices. This included the worshipping practices, such as prayer, reading the Quran, and making supplications (*du'a*) or specific prayers for different circumstances. The *sacred lens* and *sacred compass* provided the basis for the participants' cognitive and behavioural responses in daily life, particularly when they were faced with personal difficulties and periods of distress.

Seeing through the *sacred lens*. The sacred lens of Islam provided a way for participants to interpret and understand their experiences through Islamic beliefs and teachings. This informed their cognitive responses to their circumstances. This was expressed by Australian participant Hidaya who noted that Islamic teachings provided helpful ways for her to think about her experiences, "Islam ... channels my thoughts in the right way." Participants described situations where faith teachings shaped their views and perspectives in day-to-day life. For example, Mahmoud explained the concept of *taqwa* or reliance on God,

> The concept of *taqwa*, as in the trust in Allah, affects us in everyday life, as in let's say I'm going into an exam, I've studied, I've done my best, now the rest is up to God ... so in everything, in what we do in everyday life, this affects us.

Indonesian participant Fatah explained that Islamic teachings provided direction for his reactions when faced with challenging circumstances. He stated,

> As a Muslim [when] we face a problem we try to refer back to Islam. For example, when we are very upset or very cross about something then we try to refer back to that which Islam taught us, that being angry is a negative thing.

Indonesian participant Nisa expressed the view that faith perspectives help her to maintain an attitude of appreciation and gratitude. She explained,

> The Islamic foundation is the most important because in Islam we are taught that we have to be very grateful for any condition, so then when we follow that we would not consider ourselves as less fortunate compared to other people.

The findings revealed that the sacred lens shaped the participants' perspectives in focusing on Islamic beliefs and values in everyday circumstances. The participants explained that faith teachings and beliefs guided their interpretations of their experiences. This lens framed their perspectives with religious meaning and connected them with God and a greater purpose for their lives.

Maintaining Mental Health

Viewing faith as intertwined with mental health. The role of the sacred lens extended to the ways in which participants maintained their mental health (see Figure 5.1). The data revealed that maintaining mental health was closely intertwined with spirituality and faith. For example, the survey respondents confirmed the view among Australian Muslims of the interconnection between faith, religious practices and wellbeing. The overwhelming majority of respondents (99%; n = 198) selected options which indicated that they were in agreement with the statement that Islamic beliefs and practices were important for their wellbeing. Many respondents elaborated on this view such as Respondent 173 who wrote,

> Spiritual wellbeing is an important aspect of mental health. Religious rituals in Islam - such as *salat* [prayer], *dua* [supplication], *azkar* [remembrance of God] - gives us great ways to connect with Allah - which is an important remedy to mental illness.

The participants emphasised the significance of faith and spirituality for good mental health. Respondent 176 commented, “I think that Islam is connected to improved mental health and spirituality in itself makes you feel better." Further, Respondent 120 explained that, “Islam plays a large role in the lives of Muslims. In fact, it is a way of life for most ... it is a way for them to seek peace and contentment.” Finally, Respondent 141 wrote, “Islam guides us to be the best person we can be, so it does have a huge impact on my emotional wellbeing.”

In the face-to-face interviews, the participants also described the view that faith is interconnected with mental health and wellbeing. Australian participant Hidaya commented, "Islam is all about having a healthy mind, if you don't have a healthy mind you don't have a healthy soul." Participants considered that spiritual connection was essential to maintaining wellbeing. Amira, also Australian, observed, "We know that if you don't have that proper connection with Allah you're going to feel miserable ... if you do have faith you do find that it does make you feel great."

Similar views were evident in the data obtained from the Indonesian and Jordanian participants. Jordanian participant Amal explained that in her community, religiosity is commonly associated with fostering contentment and wellbeing. She stated that,

> People do believe that being religious, just being close to Allah will make you content, it's just going to make you a better person, just being happy, being satisfied with whatever Allah grants you, you will be content, you feel that whatever kind of difficulties you face in your daily life that Allah is there for you. Just do your best, this is what you're asked to do.

In summary, across the various sources, Islam was framed as having a crucial role in maintaining positive mental health and wellbeing through fostering feelings of contentment, spiritual connection and purpose. Therefore, Islam can act as a protective factor for Muslims in terms of their mental health.

Conceptualising Mental Health Problems

Weaknesses in faith. Through the *lens* of Islam, faith teachings provided a way to conceptualise the causes of mental illness. Whilst the participants acknowledged commonly recognised factors from a Western model of mental health and illness, such as biological, psychological and social factors, Islamic beliefs were prominent in explaining mental illness. Participants considered that neglecting faith and religious practices can have a role in causing, or worsening, some mental health problems. For example, Ali, an Australian

participant, stated that, “I definitely agree when they say depression can be a weakness of faith.” This was echoed by other participants, such as Amira who noted,

> To some extent, depression or anxiety is a weakness, a little bit of a weakness in faith ... we're not increasing our faith and we're just so low in it we're probably focusing on all the negatives and not having that connection with Allah.

On this point, Australian participant Rana considered that symptoms of anxiety were an indication that she needed to, “go back and strengthen my faith because obviously I lack somewhere.”

The perspective that a weakness in faith can contribute to mental illness was also conveyed by the survey respondents. Respondent 156 wrote, “The human connection to God, is very important. The lack of this connection leads to many mental health conditions.” Respondent 2 asserted that she perceives that weaknesses in her spiritual connection increases her vulnerability to mental health problems. She explained,

> The times when I was more strongly practising and more connected with God (Allah praised be He) are the times when I felt less anxious, worried or even depressed. The further we are from God, the more void we have in our hearts and souls and therefore the more vulnerable we are to psychological disorders.

Participants in Indonesia and Jordan similarly perceived a link between neglecting faith and religious practice to mental health problems. Indonesian participant Nisa explained, “What I see, people who have mental problems, if you trace their background they might not have a strong faith or they don't practice Islam as a whole.” In all, these comments reveal a view among Muslims that a lack of faith and spiritual connection can be a contributing factor for mental health difficulties.

Linking supernatural phenomena to mental illness. The *sacred lens* also provided a conceptualisation of mental illness involving supernatural beings such as angels or *jinn,* in addition to supernatural forces, such as black magic or *sihr,* and the *evil eye* or *ayn,* (i.e., the stare of an intensely jealous person). Supernatural phenomena were considered as factors

which can cause, or worsen, symptoms of mental illness. For example, Australian participant Tasneem explained that "unseen forces and things like that can lead to a lot of these mental health issues like anxiety and depression [and] Islam obviously has the answer for it." Such beliefs were apparent across the data. For example, Respondent 176 stated,

> Sometimes because they reside in your body or possession or black magic. However, apart from this, the jinn would whisper to a person negative things to eventually make him go crazy. So, in my opinion, 80% of problems are caused by evil *jinn* either by whispering or by black magic.

Respondent 133 also noted, "I believe that anxiety is related to the *wiswas* [satanic whispers] of the devil."

Although many participants referred to supernatural causes of mental illness, there were differences in their perceptions of the prominence of these forces. Some participants refuted the notion of supernatural phenomena as the *only* cause of mental illness and indicated that they are among a plethora of other possible causes. In this regard, the majority of the online questionnaire respondents (86%; $n = 172$) selected either *Disagree* or *Strongly Disagree* when asked whether they considered *most* mental health problems are caused by supernatural phenomena. As Respondent 10 stated, "While I do personally believe that *jinn* and other unseen forces may negatively influence one's life, they are not always the cause." Respondent 4 expressed the view that the effects of supernatural involvement are distinct from mental illness, "Some of them do happen by *jinn* and this needs to be ascertained if it is a *jinn* or is there any mental health issue." The perspective that there are likely to be a multitude of factors that impact upon mental health was echoed in the face-to-face interviews. As Australian interview participant Bilal stated: "We believe in the *jinn* [spirits], one is affected by that, and then they might have other psychological problems which have nothing to do with *jinn*." Despite the certain pronounced differences between Islamic beliefs and mainstream Western views of mental illness, participants did not consider them incompatible.

Coping Perspectives through the *Lens*

The *sacred lens* not only provided a way for participants to conceptualise their problems, but also offered spiritual perspectives in order to cope. Faith perspectives served to connect the participants with a sense of purpose during times of personal struggle. Participants described finding consolation in faith perspectives, such as believing in predestination, viewing personal difficulties as tests of faith, and recognising that difficulties may give rise to positive outcomes. Ali, an Australian, noted that faith teachings tend to have a positive psychological and emotional impact for Muslims when facing difficulties. "It doesn't take much, probably a *hadeeth* [Prophetic tradition] or two that they will lift someone's spirits."

Across the samples, the participants observed that Islamic beliefs offered them hope and fostered a sense of gratitude and patience with their circumstances. The participants described specific beliefs that were helpful when facing personal difficulties. Australian interview participant Sameera observed that faith teachings can have a profound impact for Muslims facing difficulties.

> There is nothing that will catch [Muslims] more and encourage them more than to put that element [of Islam] into it, cause it's an element of hope, it's something to strengthen your spirit so your spirit is not broken by the illness. If your spirit is broken no amount of counselling or medication will help you. It really needs to come from within, so if that's broken, the doctor is not going to get anywhere with that person.

Sameera further commented that "the spiritual healing in Islam itself is really great" and that faith provided her with a sense of optimism that her situation would improve. Rana, also an Australian interviewee, asserted that her faith was a central part of her recovery from an anxiety disorder, particularly her conviction that help would come from Allah. She stated that,

> Allah is the only way of me getting better, He puts in us and He takes away from us, He brings us to life and He takes away our life, and it's only through His power and His mercy that we can be and do, and have whatever we have in our lives.

Other participants similarly explored the way in which faith provides a sense of comfort, hope and optimism during times of difficulty and crisis. Lina, a Jordanian participant, noted that reliance upon faith is common among the Jordanian people, and that this has positive outcomes for their coping and mental health.

> Many people have this faith … and that's what makes things easier for people here. And even if you compare the suicide rates here and in a non-Muslim country you will see it's less here … they look at their faith and religion, Islam, as something that consoles them on their daily problems and tensions.

The survey data confirmed the concept of Islam providing adaptive perspectives which help Muslims to manage mental health problems. As Respondent 128 highlighted: "Religion plays a big part in my life. It allowed me to stay positive in my hard time, it also allowed me to be more understanding about why things happen. My religion helped me when my husband passed away." Respondent 108 commented on the significance of religion in her coping:

> Life brings with it many ups and downs and throughout my life I have been through many downs with depression and many suicidal thoughts, the only thing however that has made me stronger and given me happiness and stops my depression is Islam, I feel that without it I probably wouldn't be here today.

Respondent 97 described how he had been supported through faith, "I'd be completely lost without religion. Faith gives me a sense of hope for things." These comments show that drawing upon specific beliefs and faith perspectives assisted respondents to foster a sense of internal strength.

Believing in a purpose for life events. The participants noted that believing in a greater purpose helped them during periods of hardship. They indicated that this belief assisted them to shift their focus from their difficulties to considering a broader and more meaningful perspective. Australian participant Hanan referred to the ability to associate

times of difficulty with a greater life purpose, “There's a vast difference with Islamic counselling ... it's pretty clear cut and it's also spiritual guidance ... there's always a reason for everything.” For Hanan, believing in a reason for her problems was helpful as she indicated that in time, this would become apparent. Jordanian participant Maha described finding comfort that there is a greater purpose for difficulties in her life, believing that help would come from Allah.

> Having something to believe in is really helpful, having this feeling or belief that there's a very strong power from Allah all around you, that everything is happening for a reason, it does help you to understand the bad things that happen in your life and to accept them, which really keeps you from going through such a mental problem that you could need to see a psychologist because of it.

Lina commented that believing in a greater purpose helped her to be optimistic in difficult times. She stated,

> I think being a Muslim really helps 'cause like everyone says you have to have patience ... this is what's meant to be for you ... you have to be patient and something better is waiting for you. And these words really have an effect on people. So, it's like believing that this is happening for a reason.

Believing that something better would arise through the experience of personal problems helped to foster patience and optimism through their difficulties. Participants described finding comfort in believing in a greater purpose for their struggles.

Believing in predestination. The concept of predestination, that certain events are destined to occur, was repeated across the data. According to this belief one’s circumstances are the will of God and therefore nothing could have prevented the difficulties from occurring. This belief was described as being helpful to manage feelings of regret, anger or disappointment for one’s circumstances or problems. Reminders of predestination connected the participants with a sense of patience and acceptance for personal difficulties, rather than thinking that their situation could have been different. Hani, an Indonesian participant, explained that her husband died in a sudden accident when her three children were young.

During this time of profound loss, the concept of predestination helped her to accept her tragic circumstances. She stated that, "Allah has already given all your story in life, when you're going to be born, when you're going to be married, when you're going to have children, everything." Similar to Hani, Jordanian participant Maha reflected on the breakdown of her marriage.

> Believing in destiny ... for my problem ... I was distraught or devastated at some point, I was like really, really sad [but] I knew at some point that it's meant to happen, and Allah meant it to happen, because Allah wants to save me from a worse situation. I know this [situation] is hugely bad, this is not really what I hoped for my life but it's better than a worse situation.

Lina explained that she reminds her friends of predestination when they are going through times of difficulty as this provides comfort and reminds us to be accepting.

> I know many friends of mine ... who went through problems like this and they were depressed and like everyone was telling them you have to be patient, Allah wrote this for you and you have to understand that and it really helped.

The survey respondents similarly referred to this belief. Respondent 7 wrote, "The Islamic perspective helps people with mental problems if they believe in the destiny and when they think everything is from Allah and is the best for them." Respondent 176 commented, "Belief in Allah's decree and accepting what He has tested you with helps for many problems. I think prayer and *du'a* [supplications] help a lot too." In summary, a belief in predestination assisted the participants to develop an accepting and patient attitude when experiencing difficult circumstances.

Holding hope for positive outcomes from difficulties. The participants described turning to a belief based in Islam that positive outcomes can arise from hardships. This perspective helped them to be hopeful, as they viewed difficult circumstances as potentially giving rise to something better in their lives. Australian participant Rayann explained that: "It comes back to our belief, anything bad that happens to us we believe that good can come

from it, so there's nothing really to be depressed about." Similarly, Indonesian participant Hani noted:

> [It] makes the way of thinking more positive ... Allah created something for you behind but you don't know what, maybe you think that's bad but it will be better. Sometimes humans just see everything bad, but Allah knows the best ... If God gives the problem, God created the [solution]. You have to try to solve the problem, but you have to believe God made that problem just to increase your level [of faith].

Hani viewed difficulties as a means of strengthening her faith in that she turned to religion to solve her problems. Similarly, Indonesian participant Fatah commented:

> Another thing is that when we face a problem Islam teaches us to be optimistic so that's how Islam will affect in solving these problems. Every time a Muslim refers back to Islam it will strengthen them.

Participants considered that difficulties can give way to beneficial outcomes and that such a view is very helpful. This assisted them to maintain an optimistic mindset and consider the positive possibilities that could arise.

Believing in Allah's help in providing solutions. The participants described believing with certainty in Allah's help for their difficulties and that there would be a solution for their problems. Australian participant Sameera explained,

> Whenever there is a difficulty there is an opening, there is a way out ... this is guaranteed, there is no problem that will be closed forever. All you have to do is to look for the solution and be patient until you get to the solution.

Indonesian participant Hani observed that believing in Allah's help was essential to staying positive during her most difficult times.

> It's easy to talk, but when you're facing [problems] sometimes you say I just don't want to do anything, like you give up ... But I always believe Allah will send somebody to help you to solve your problem, so I just believe on that, so He [won't] leave me alone, doesn't matter how big the problem.

Jordanian participant Nur referred to the perspective that solutions to personal difficulties can be found in sacred texts. She stated, "[In] the Holy Quran there is solution for everything in

this life." Similarly, Maha stated, "I think Islam does help us ... Like for everything, there is a solution." The certainty that there would be a way out of their difficulties assisted the participants to remain confident that, in time, there would be a resolution.

Viewing difficulties as tests. Participants noted that perceiving their challenging circumstances as tests from God connected them with a higher purpose. Hani, an Indonesian participant, explained,

> The purpose of our life, it's only for test ... tomorrow, next year, next twenty year we will have test all the time, this means you will have a problem, so just be ready. And Allah will not give you test more than your capacity, so just believe on that.

Australian participant Ali indicated that this mindset assists him to cope with difficulties:

> If I'm ever affected by a problem I like to look at the big picture and think Allah will make things easy, this is just a trial, and it'll become much easier for me to accept some things that happen in life.

Challenging situations were therefore seen as a means for beneficial outcomes, such as a way to increase the participants' faith or strengthen their character. Participants noted that they found the reminder that difficulties are tests as helpful, particularly as they believed that their difficulties would not exceed their ability to cope.

Following the *Sacred Compass*

Whilst the *sacred lens* provided a way for the participants to view their experiences through Islamic beliefs, the basis for choosing appropriate behaviours and actions was guided by the *sacred compass* (see Figure 5.1). This was reflected by participants' use of words such as *guiding* and *giving direction* when referring to faith teachings. As expressed by Australian participant Bilal, "[Islam] keeps you balanced, so therefore you have direction." Participants explained that Islamic teachings drawn from the Quran and *hadeeth* [Prophetic traditions] contain detailed guidance for all spheres of life, such as work, family, social interactions, financial affairs, dress, food and drink. As a result, religious teachings informed

their responses to various situations. Adnan, an Australian participant, commented, "I think [Islam] is very important, it guides every aspect of my life."

Participants described the way in which the *sacred compass* directed their conduct and behavioural choices. Australian participant Amir indicated that throughout his day, he is conscious of his actions and behaviours, ensuring that his choices are consistent with the goal of pleasing God. He stated,

> Before doing anything in my life, I think Islamically should I do that or not, for anything, inside home, outside home, everywhere, in my work, dealing with my colleagues. I'm trying to consider that Allah is watching me all the time, so I'm trying to avoid whatever makes Him angry or displeased. It is [a] really important thing.

Participants emphasised the significance of adhering to Islamic guidelines of behaviour. Imran explained that, for him, Islam is "very important. I don't do anything which is against my religion, doesn't matter how pleasing it is, I won't do it." He noted that as a practising Muslim, he adheres to certain boundaries of behaviour, even if they conflict with his own wants or desires.

> There are plenty of things you can go and do and enjoy yourself ... but being a Muslim we can't do all that ... like go to a nightclub, take up gambling, take up smoking, take up drinking ... we can't do all that.

Hidaya similarly noted that due to following Islam, she refrains from being involved in behaviours which breach religious boundaries.

> I'm very grateful for Islam, like the way I interact with other people... like at the moment we have Uni Ball, [and my friends say] come, come, like no, I don't go in those kinds of environments ... I don't drink, what am I going to do there, I'm not going to dance.

Australian participant Mahmoud described how Islamic teachings guide his conduct in his social interactions.

> In interpersonal relationships, making friends, at school, at work, especially with relationships, religion affects this quite a bit, as in be good to your neighbour, be good to your co-workers, be good to your friends ... be a good example.

Ali explained the role of Islam in directing behaviours, "a proper Muslim wouldn't go out there and drink or wouldn't go out there and steal something from a shop because his values are guided by their religion and religion guides our behaviour in our everyday lives."

These comments present Islam much as a compass, playing a fundamental role in the participants' choices. This compass served to restrict the participants' from acting upon individualistic desires and ensured that their actions stayed within the limitations of religious principles. Through choosing actions within the bounds of Islam, participants sought to gain spiritual connection to God.

Coping Behaviours by the *Compass*

The *sacred lens* provided a way for participants to view mental health and illness, and offered adaptive coping responses, while the *sacred compass* guided their actions and choices. In times of experiencing personal problems, Islam provided practical responses for the participants. Hidaya, an Australian, asserted that: "The Prophet has given us solutions to almost everything ... so with depression, how to combat those things, there is a way." Zayd considered that being a practising Muslim involves utilising Islamic guidance when facing problems: "I think if you want to practise your religion then you want to understand that stance of Islam. So that's where you find that value." He asserted that for Muslims, faith teachings provide examples and methods to address personal problems:

> It's all about religion and it's all about the Quran and they're things that we should apply in our everyday lives. These are the best examples. If you open a book and go through the Quran and you understand the real wisdom behind some things, they may not be apparent at first sight, but if you look into why things were revealed and if you look at different methods of conflict resolution and have a Muslim counsellor who really understands all these different methods and applies these different methods and teachings within their counselling services then I think this is the most beneficial for the Muslim community.

Hanan explained that Muslims can deal with problems through acting upon Islamic teachings. She said,

> In our religion it's all about finding a way and being strong within Islamic guidelines. There's no weakness... You go through a tough time but then you pray... When you turn to Allah things are going to get better.

Indonesian participant Rahmat similarly discussed the value of drawing lessons and advice from sacred texts to address present problems. "My opinion is a psychologist is the last destination, not the first, because in Islam, in the Quran and in the *hadeeth* [Prophetic traditions] Allah and his Prophet has shown us how to solve the problem." A similar view was expressed by Fitri, also Indonesian, who stated that she strives to approach her problems through religious perspectives and practices: "I'm training myself to always have the solutions from spiritual ways, by praying, by *du'a* [supplications] ... I try to understand more about Islam, to practise it and understand how it affects me and the family."

On the survey, respondents emphasised seeking help through religious practices. Respondent 41 wrote,

> Although people most definitely benefit from speaking to counsellors, I strongly feel as though I can overcome any kind of stress be it mental or otherwise that I may face now or in the future by turning to Allah. I have found this to be extremely helpful at times of adversity and I have never had to turn to anyone else to seek assistance in this regard.

Respondent 184 commented on aspects of Islam that are helpful during difficult times: “The advice from Prophet Mohammad in regards to issues/problems that one might be experiencing. For instance, the supplications that one can recite when experiencing anxiety.” In sum, seeking advice, lessons and guidance from Islam was seen as a central part of coping. Participants were confident that this is the most effective way for them to respond to their problems.

Seeking help through prayer. Engaging in formal prayer was identified as a main response to coping with difficulties. In Islam prayer requires ritual washing of certain body parts with water (*wudu*), facing Mecca, reciting Quranic verses in Arabic and engaging in a series of specific movements, such as standing, bowing and prostrating. Layla observed that

it is common for Muslims to turn to prayer as a first response before seeking help from other sources: “In Islam we have a personal relationship with Allah. That is how we all believe you solve the issues, so through your problems you beseech Allah before anything else or anyone else.” She considered that seeking help through prayer played a major role in overcoming periods of difficulty in her life. “I do believe that I did overcome my issues through my relationship with Allah and through praying. When going through a time of hardship you need someone to remind you about these things.”

Engaging in prayer was described by the participants as providing a sense of comfort when experiencing intense stress. Prayer was something that the participants could engage in when they felt pressured and it provided relief. Indonesian participant Dina commented on the significance of prayer in coping with raising a child with an autistic spectrum disorder. She said, "When I feel very depressed and just fed up, I just pray and ask Allah for His help." She explained that prayer is particularly helpful in coping with her daily challenges:

> It is important when we continue to have [faith] praying to Allah because then it can reduce the stress, the level of stress within us and it can calm us down and it would teach [me] to accept the condition that Allah has given to me.

The Jordanian participants echoed such sentiments. Nur commented that engaging in prayer fosters certainty that Allah supports her.

> In my opinion, I think that if you need some help or if you are depressed, you can talk with Allah. Sometimes I feel that I am under pressure, a lot of pressure, I need just to be alone and to be with Allah ... If I feel depressed, I go to my carpet and pray to Allah ... I am sure 100 percent that Allah will help me in this life, better than my mother or father or sister or any friend. I know that Allah is the only one who helps me. So direct, I go to my carpet and pray.

Australian participant Amir described prayer similarly, as a source of support that he can turn to when feeling highly distressed.

> In some cases, I feel I'm locked in a very tight jail, I'm feeling it's getting tight and I cannot even breathe. So, I seek help from Allah, I go and ask help to free me from what I'm feeling. To some extent almost everything is resolved by seeking help from God, generally speaking, seeking help from Allah is always helping.

Indonesian participant Rafi described experiencing a feeling of support and spiritual connectedness to God through prayer.

> At the end, we go back to Allah, only Allah beside us. All of us have our own problems, so at the end we are alone, and then what do we do, we just pray ... It's between yourself and your creator, that's quite important.

Also, for Indonesian participant Rahmat, praying helped him to feel close to Allah, especially when facing hardships. He stated,

> Until now if I have a problem I just wake up in the middle of night ... and I say to Allah that I have problem like this ... could you help me? So, what will happen next, I believe is the answer from Allah, and I never go to a psychologist, except maybe just share the problem with my close friend. Only that and read Quran, because I believe fully that Allah is very close with us in the middle of night and if we come to Him with a holy heart He will answer, and at least He gives us the peace in our hearts.

From the survey data, Respondent 42 commented on the calming quality of prayer. "The prayers itself could help in many ways. It's somehow a form of meditation, where people only connect with Allah and with their inner self."

Prayer was a fundamental part of the participants' coping as it provided them with a connection to Allah, helping them to not feel so alone in their struggles. It had the benefit of being easily accessible, could relieve feelings of intense stress and give the participants a sense of agency, that they had the means to manage their difficulties.

Reading the Quran and making supplications. In addition to prayer, the participants across the samples highlighted the value of reading the Quran and making supplications (*du'a*). There are certain verses of the Quran which provide lessons, adaptive perspectives and words of comfort. Supplications are informal prayers which can be said for specific situations. These are sometimes drawn from the sacred texts of the Quran and Prophetic traditions. Australian participant Rayann reflected, "In the past when I have been a bit depressed, my pathway has always been my religion. I always go back to sit down and

read some Quran or pray more or make more *du'a* [supplications]." Zayd commented that supplications (*du'a*) provided a feeling of immediate connection to Allah. He explained,

> It [Islam] plays a really great role, you have that direct connection with Allah, if you're facing an issue then you can make du'a [supplications] and we've got other things like hadeeth [Prophetic tradition] where he said certain things in certain situations and they've helped.

Jordanian participant Maha likewise commented that in her community religious coping is commonly a first response. She observed: "I think religion, *dua* [making supplications] makes a big difference and it does make you feel comfort inside when you just keep repeating *dua*." The survey respondents also mentioned using supplications. For example, Respondent 44 commented that, "When you are a practising Muslim, faith in Allah helps you no matter what situation you are in and how we are feeling ... making *du'a* [supplications], praying to Allah."

These responses revealed the way in which Islam informed the participants' responses to personal difficulties and crises. They identified a crucial role for religious coping that involved religious practices, such as prayer, reading the Quran and making supplications. These practices were associated with a sense of calm, support and spiritual connection.

Conclusion

Despite the cultural differences between the Muslim minority and Muslim majority samples, religion occupied a central role in participants' lives. Across the samples, there were striking similarities in the descriptions of Islam as what may be conceptualised as a *lens* and *compass* in maintaining their mental health and coping with personal difficulties. These concepts provide the foundation for understanding the way Islam is integrated in the everyday lives of Muslims.

The research provides insights into the ways in which specific religious perspectives give meaning to Muslims' experiences, in addition to directing their behaviours and choices

each day. The participants considered that faith perspectives and religious practices were inseparable from their conceptualisation and treatment of their mental health difficulties. In accordance with the integration of Islam in their lives, religious beliefs and practices provided helpful responses to their problems. Faith perspectives provided participants with a sense of hope, comfort and optimism and religious practices provided a sense of support, relief and spiritual connectedness. The findings suggest that for Muslims, religion tends to have an adaptive role in their coping, regardless of their cultural background.

The following chapter will discuss the help-seeking pathways of the participants. The chapter will expand upon the concepts of the lens and compass to explore the role of Islam for Muslims in seeking help for their mental health problems. This exploration will examine factors relevant to seeking help, particularly religious and cultural influences. As such, the chapter will identify a range of barriers and facilitators for participants in their help-seeking process.

Chapter 6

In Search of Healing: Muslims' Help-Seeking Pathways

The previous chapter explored the meaning of Islam for the participants, revealing the central role it plays in all spheres of life. The chapter clarified some of the ways in which Islamic beliefs and teachings impact upon participants' perspectives and actions. Across the diverse samples, Islam was found to provide helpful ways for participants to understand and respond to their difficulties. This examination revealed that Islam informs participants' perspectives and choices in all circumstances, including the conceptualisation of mental illness, maintaining mental health, and coping responses to mental health problems.

In this chapter, the exploration of the role of Islam for Muslims in coping with mental health problems is extended by examining patterns in help-seeking. This chapter seeks to understand Muslims' responses when faced with mental health problems and examines the range of factors that impact upon their choices in seeking help. This is represented in Figure 6.1, "Muslims' Help-Seeking Pathways", where the key stages in the participants' help-seeking processes are outlined. These include being assisted by family, seeking religious guidance in turning to spiritual healing, and accessing professional treatment. These stages highlight the role of cultural, religious and community influences in this process. This chapter explores a range of considerations that facilitated and inhibited the participants' access to mental health services. Similarities and differences across the Australian, Indonesian and Jordanian samples are identified.

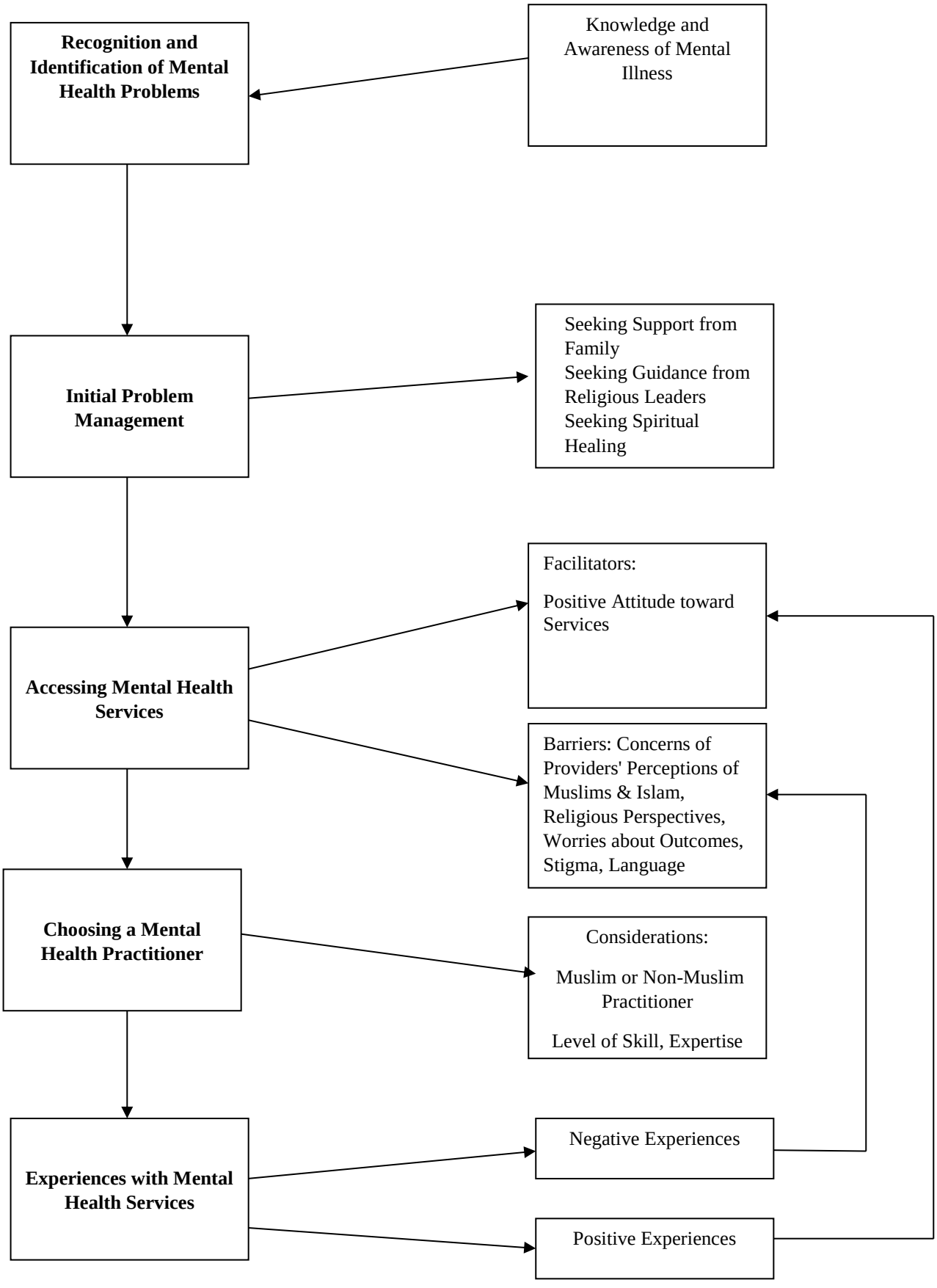

Figure 6.1. Muslims' Help-Seeking Pathways

Recognition and Identification of Mental Health Problems

Knowledge and awareness of mental illness. When considering help-seeking for mental health problems, the participants identified that an essential first step is recognising symptoms of mental illness (see Figure 6.1). Participants across the samples highlighted issues with recognising mental health problems within their communities. They noted that a lack of identification may result in sufferers failing to seek help for treatable mental health conditions. Australian participant Adnan observed, "A lot of times it could be easily treatable, but they may not necessarily know that because it's not something that they hear about, [but] it depends on the person's education." Similarly, Zayd commented,

> … people might have a mental illness and someone just says that's just how he is .... if we don't know what the signs are of mental illness, we don't know what the symptoms are and all those sorts of things then how do we know someone's mentally ill? We could think that's just how they are.

Australian participants Rana and Imran recounted their experiences of failing to identify their own mental health conditions. Rana explained that she had been unaware that she was experiencing symptoms of anxiety. "Initially I just went to my doctor and I felt that things weren't right; wasn't feeling myself .... this wasn't my normal behaviour and character." It came as a shock to Rana to be diagnosed with an anxiety disorder. Imran likewise commented that he had suffered from depression for an extended period of time before it was recognised. He stated, "I used to feel bad and sick and a time came when I used to think, oh I'm a failure, I can't do much, I've done nothing in life .... I thought this is just me." Imran's treatment was instigated by his friend, who recognised symptoms of depression and convinced him to seek help. For Imran, his experience made him realise the importance of being aware of mental health issues in order to detect the need for treatment. Further to this, Imran expressed his concern for others in the Muslim community who may similarly fail to recognise that they need help:

> I feel sorry for so many people now that they don't even know what they're going through and it can be treated ... there is no right person for them to talk [to] and to make them understand that this is not you, that happens and it can be treated.

Participants pointed out that the level of knowledge depends upon a range of influences such as education, prior exposure to information about mental illness, experience with mental illness, and level of acculturation. As Sameera stated: "There's a difference, I believe, in Muslims too. Like, there can be the older Muslims who just don't take it into consideration and the younger Muslims who are brought up here [Australia], who do know about depression and anxiety."

Participants drew attention to the limited discussion about mental illness in forums involving the Muslim community, such as in sermons during Friday congregational prayers or at Islamic lectures. According to Zayd, a lack of discussion of mental health in the Muslim community contributes to a lack of awareness about mental illness:

> There's probably not a great deal of education within the Muslim community about mental illness ... I can't think of a time when the Imam got up and said, "Today we're going to talk about mental illness" ... I would say there's probably a lack of awareness about it.

Participants highlighted that information about mental illness, which specifically concerns the Australian Muslim community, is needed. Amir stated, "I never ever heard about any advertisements or anything like encouraging Muslims to go to psychologists. I never go to a mosque or something like that and ... see any sort of advertisements [for mental health services]." According to Amir, in order to increase awareness among Muslims, information should be placed in mosques, Islamic centres, and other Muslim organisations. He said that,

> If it is something in the local paper or something like that I will not pay much attention. I will not feel that it's something related to me. But when I see something in the mosque I will consider it as it's for Muslims. So I will consider that it's specifically tailored for me.

Mahmoud similarly noted that there is a need to increase community awareness among Australian Muslims.

> I think Muslim psychologists have a very hard job for the coming years, because they've got to arrange a lot of activities, as in seminars, talks, and so forth to actually make the community aware of mental health problems for the community to become a better place.

Participants acknowledged that raising awareness among the Australian Muslim community is necessary to increase identification of mental health conditions and thereby improve access to appropriate treatment.

Concern about the awareness of mental illness in the Muslim community was confirmed by the survey participants (see Table 6.1).

Table 6.1. Survey participants' attitudes toward information and education about mental health (*N* = 200)

Survey Item	Response	*n*	(%)
The Muslim community needs more information and education about mental health problems and available services	Strongly Agree	110	(55.0%)
	Agree	89	(44.5%)
	Disagree	1	(0.5%)
	Strongly Disagree	0	(0.0%)

As shown in Table 6.1, the overwhelming majority (*n* = 199; 99.5%) of respondents agreed that more information and education about mental health is needed for Muslim communities. In this regard, participants such as Respondent 19 noted that:

> There is an abundance of problems amongst the Muslim community that a lot of Muslims don't want to recognise and want to brush it under the carpet so to speak. We have a lot of Muslims who suffer from the same problems as the rest of the world, but a lot of Muslims just fail to recognise that these things exist, and just think that they will grow out of them, or that it is normal. A lot of specific cultural groups don't want to deal with problems that arise like marital discord, and a lot of the times the person affected just gets pushed aside.

In the Indonesian and Jordanian samples, participants also noted that there was a need for greater awareness of mental health issues. Jordanian participant Lina commented, "The first place like they should know that they have something wrong [but] many people do not accept this idea, like they say I'm fine, so they don't know really that they do have something

wrong." Indonesian participant Fitri emphasised the link between an awareness of mental health conditions and seeking treatment. She stated, "One of the problems [in Indonesia] is that people do not really understand about the psychological help ... because they are not aware, they don't understand." The recognition of symptoms of a mental health problem was therefore seen as a necessary step in seeking help.

Initial Problem Management

Seeking support from family. The participants from Australia, Indonesia and Jordan emphasised that in their communities, family support was a vital part of their problem management and help-seeking process (see Figure 6.1). Australian participant Amir observed that culturally, the family unit plays a significant role in addressing problems. He stated, “Generally speaking they are referring to family members who are wise parts of the family ... usually they are elders in the families.” When problems could not be resolved adequately with the help of family, it was common for participants to indicate that they would seek help from religious leaders. As Imran described, “Mostly it's been settled within the families, if not then the local imam.” Amin described the steps of first seeking help from family, then from the community, and then from the local sheikh.

> In our community, the first thing we try to do is we try to solve our own problems, so the parents get involved if they can solve it. If not, someone else who is highly regarded in the community will try to get involved. When they can't, they go to the sheikh.

The Indonesian and Jordanian participants gave greater emphasis to the support provided by family. This is consistent with an emphasis on family and community interdependence in their cultures, coupled with the lack of available mental health services (Al-Krenawi & Graham, 2000; Tampubolon & Hanandita, 2014). Indonesian participant Fitri stated that, "Mostly [Indonesians seek help from] the closest family relatives, their closest neighbours, community leaders. We have a head of the village, then especially if they trust

the religious leaders, they go to the religious leaders." Turning to village leaders distinguished the Indonesian participants. For Indonesians who are closely connected to the traditional village community, the head represents a distinct source of advice and assistance.

The family was considered an important source of assistance due to their closeness and familiarity with each other, whereas mental health professionals were referred to as "strangers". Indonesian participant Nisa explained, "If you ask me, going to a psychologist when I have a personal problem would not be my priority. My first priority is my family, second my Islamic teacher." The Indonesian and Jordanian participants noted that if they were to access help from mental health professionals, their families would still play a role. For example, Rafi commented:

> It's okay, no problem [to go to a counsellor] but we have to think twice about going there. We usually share it first with our family or our really best friend, [and ask them] should I go there, something like that.

Jordanian participant Lina described the significance of family in responding to personal difficulties, "Family here is a very important thing, and like taking this support from family really helps because everyone is around you, even friends. You will not feel that you are alone." Likewise, Nur commented that elder family members are often sought for their advice and assistance.

> If we have any problem, we go to the [elders] within the family. Maybe [they] have more wisdom than anyone else in the family. My uncles and my aunts, if they have any problems they go to my father because he is the oldest within the family, or my grandma.

However, Lina noted that people may be selective regarding the problems that they choose to disclose to family members. She stated:

> Problems in marriage or these things usually like woman and man they keep these things between them and they don't want to get everyone involved into their problem. In this case sometimes you see yourself alone. But if you want to tell the family about this you will see everyone around, everyone supports you.

Seeking guidance from religious leaders. Across the samples, participants described a prominent role for religious leaders in assisting Muslims with mental health concerns. The participants described religious leaders, such as an *imam* or *sheikh,* as being highly respected in their communities, providing both knowledge and guidance for personal issues. Seeking their help for personal problems was a way to gain religious perspectives and spiritual guidance to cope with difficulties. For example, Australian participant Layla commented that, "I think most people in the Muslim community would go first to a sheikh over a counsellor ... they offer the spiritual guidance, because a lot of people do feel like they can solve their issues through Islam." Bilal observed that when faced with personal difficulties he would seek advice from a religious leader to gain Islamic knowledge that applies to his situation. He stated, "For me, it'd be going ... first of all to someone of Islamic knowledge, especially when it comes to family matters." Amir described a number of advantages in seeking help from religious leaders when he stated, "The very nice thing about the sheikhs is that they are usually from your background, they are speaking your language, they understand your religion."

For participants from Indonesia and Jordan, local religious leaders were similarly described as performing an important role by providing guidance for personal problems. Indonesian participant Anas explained that:

> It's culturally not common here when they have [mental problems] to go to doctors, but they go to someone who can strengthen them, either spiritually or in motivation. But not to a doctor or a formal institution where they might need medicines and treatments.

Rafi noted that seeking help from religious leaders was preferred in his community in order to obtain advice that is consistent with Islamic beliefs. He noted, "They want to solve their problem by using Islamic law, not just releasing their stress and then just have fun, something like that. They want to have an answer that made them closer to Allah." Rafi gave an

example of seeking help from a local religious leader when his parents divorced. He explained, "The main important thing is we consulted with an Islamic scholar; they will give a solution which is acceptable to Allah."

The Jordanian participants provided similar descriptions of seeking help from local religious leaders. Amal commented that a sheikh or local imam is often consulted as Muslims tend to prefer solutions for personal difficulties within Islam. She explained,

> Sometimes what happens is parents or close friends or family members would talk to a sheikh on behalf of that person, to see if [their problems are] because that person's not religious, "what do you recommend they do?" ... religiously speaking, to get closer to Allah, and then all these problems will just go away. But people would basically depend upon friends and family members to try to solve these things ... more than anything else.

Despite the prominent role for religious leaders in providing guidance for Muslims' personal issues (especially in Muslim majority countries), the Australian survey responses were concerned about seeking their help for mental health difficulties (see Table 6.2).

Table 6.2. Survey participants' perceptions of religious leaders in supporting Muslims with mental health issues (N=200)

Survey Item	Response	*n* (%)
If a Muslim is suffering from emotional/psychological problems he/she should seek advice from a local imam before seeking other services	Strongly Agree	16 (8.0%)
	Agree	60 (30.0%)
	Disagree	96 (48.0%)
	Strongly Disagree	28 (14.0%)
The imams in the Muslim community have a good understanding of mental health problems and treatment	Strongly Agree	6 (3.0%)
	Agree	34 (17.0%)
	Disagree	96 (48.0%)
	Strongly Disagree	64 (32.0%)

As indicated in Table 6.2, more than half of the survey respondents did not consider that religious leaders were an ideal source of help for mental health problems or have sufficient understanding of mental health. Related to this, Respondent 4 indicated, “They do try to

provide whatever support they can give but unfortunately they have not been trained to do this. Whilst some may become good at it by experience but this is widely lacking." Other survey respondents stressed the need for religious leaders to receive training in mental health. For example, Respondent 29 noted, "It would be important to give imams involved in this some basic training to improve their effectiveness because they should be the first port of call for such issues."

Overall, the participants saw a role for religious leaders in providing guidance and faith perspectives for personal problems. However, the Australian respondents were concerned about religious leaders' knowledge of mental health and this limited the assistance that they could provide.

Seeking spiritual healing. As described in the preceding chapter, it was common for psychological conditions to be attributed to supernatural causes such as black magic (*sihr*), spirits (*jinn*) or evil eye (*ayn*) in the participants' communities. As such, participants said that they preferred to be treated with spiritual healing from religious healers, such as an imam. This involved healing through Quranic verses, known as *ruqi'ah.* As shown in Figure 6.1, spiritual healing is a form informal help used in the initial stages of problem management. Australian participant Bilal noted that,

> He [the imam] will read [the Quran] upon them, see if there's anything wrong ... if nothing settles there then we seek professional help, which could be a psychologist or somebody who can deal with these things ... but firstly ... we go through the Islamic proceedings ... then we send them off to someone who has a profession and to see what it is.

The survey respondents similarly drew attention to the use of spiritual treatment in the Muslim community. Respondent 183 wrote,

> Counselling and medication might not be the answer for certain people, as the patient could be experiencing difficulties from demons (*Jinns*) or Shaitan [Satan]. In this situation *dua* [supplication] and or *ruqi'ah* [Islamic healing] derived from the *sunnah* [way] of Prophet Muhammed would be advisable from Islamic scholars and Imams.

Supernatural phenomena were identified as an explanation for mental health problems in both the Muslim-majority and Muslim-minority samples. As in Australia, the Indonesian and Jordanian participants revealed that spiritual healing is widespread in their communities. However, there were differences in the types of spiritual treatments used. Unlike the Australian participants, the Indonesian participants noted that spiritual treatments may be derived from a range of cultural and religious influences, such as aspects of Hinduism and Christianity. Dina observed that spiritual healing practices differ depending upon the province or district. "Each city or province they have a special culture and they have a special belief ... it's popular for them to meet with a shaman." The Indonesian participants differentiated these local healers from Islamic leaders. Participants explained that Indonesians sometimes seek spiritual cures from these healers for physical illnesses. Dina stated,

> Not only for mental illness, [they] pray for [a cure] for cancer. "Oh, meet this man, he's in the mountain, you can go to him, he can cure anything." So, they still go to this thing, it's still very strong within the society.

Quranic verses are sometimes used in these therapies, in addition to other cultural practices. Fitri explained, "Usually they use spiritual therapy, such as reading the Quran in the middle of the night and then they shower them with cold water ... this kind of therapy is given to them." Dina described other rituals, "they give either massage ... they shower with flowers, they said to throw all the evil away, lots of different kind of things." Participants made a distinction between healing based on Islamic teachings and culturally-based practices. Dina explained that her son was diagnosed with Autism and, despite her preference for professional treatment, she consulted the local imam due to pressure from family elders. Dina was relieved when the imam advised her to seek professional help. She explained,

> Luckily when I went to one, he told me something good, which is, your son can only be cured with your help and God's ... don't listen to other alternative therapies, go to a

> professional psychologist, give [him] therapy, you look after him and pray to God. That's what the one I met told me.

The Jordanian participants similarly observed that spiritual healing is common when problems are considered to be related to supernatural phenomena. Amal explained,

> I think sometimes what happens is that they would call for a sheikh to recite Quran for that person, we call it *ruqi'ah* when you bring in the sheikh, you make *wudu* [ablution] or like you have water, they read Quran on the water and they make that person drink it hoping for these problems to disappear, so people sometimes think of that option at some point.

Jordanian participant Nur discussed her personal experience with seeking spiritual healing. She explained that in her final year of secondary school she struggled to focus on her studies and her academic performance fell dramatically. Until that period she had excelled. She explained that her family believed the problem was, "*ayn* [evil eye] and *hasad* [jealousy from others], very strong." Her family sought spiritual healing for her from a local sheikh. Nur described the situation:

> My experience in this issue, in the first time I didn't believe that there is *sihr* [black magic] or *jinn* [spirits] or *hasad* [jealousy] or something like this... All the time I have headache and I can't read the book, I can't do anything in my life. Then my grandmother said to my mother and father, go to the sheikh. Maybe she needs someone who can read the Quran in a strong way. And I go to the sheikh ... and I read the Quran for three months. In the first semester [in the final year] my average was 73. In the second semester, my average was 97 [after that] I studied in the university ... and I was the first student in my college [on a scholarship].

These reflections show not only that spiritual healing is a common treatment across varied samples of Muslim participants, but also that spiritual healing is considered to be an effective option for certain mental health difficulties. Among the overseas samples, informal treatments such as spiritual healing were clearly favoured over accessing mental health services. Whilst the Australian participants were more open to accessing professional mental health assistance, seeking professional treatment tended to be a fraught decision. A range of complex considerations appeared to either facilitate, or inhibit, their access to mental health services.

Accessing Mental Health Services: Facilitators

Favourable attitudes towards services. As depicted in Figure 6.1, a positive view of mental health services emerged as a key aspect in accessing mental health treatment. Such attitudes were particularly evident in the Australian data. In regard to the interviews, 19 of the 20 participants expressed favourable attitudes regarding the usefulness of professional mental health services. This contrasted to the Indonesian and Jordanian interviews, where only one participant from each sample expressed positive attitudes.

Australian participant Hanan reflected upon the benefits of mental health services stating, "I think it's a great thing. If you have an issue and you don't get the skills to deal with it, it's going to go on forever." Similarly, Zayd commented, "People go through issues, people have problems and you need a voice of reason or someone to discuss your issue with." Amira considered that counselling can be helpful for a range of problems. "Definitely [beneficial] from issues that little kids have right through to marriage counselling and family counselling."

Due to the central role of religious beliefs and practices in participants' lives, the compatibility of professional mental health treatment with their religion was a relevant consideration. According to the Australian participants, their religious perspectives and practices could be complementary to mainstream models of mental illness and its treatment. For example, participants considered that beliefs in supernatural phenomena did not preclude a mainstream view of mental illness that included biological, psychological and environmental causes. As such, there was an overlap between the participants' religious beliefs and mainstream models of mental illness and treatments. In this regard, participants asserted that Islamic teachings encourage an openness to seeking help from other sources. Sameera explained that,

> Islam never tells you just sit and read Quran and you will get better. It never tells you that. Islam says there is no illness that does not have a cure. Depression has a cure. It's just a matter of looking for it. So that really helped me a lot to understand that every problem has a solution.

Amir clarified that although turning to prayer is a priority for him, this does not exclude seeking assistance from other sources: "I understood God asked us to seek help from him, but part of seeking the help from him is to go to a doctor in case you have a problem. This is part of the help itself."

The survey results similarly provided positive perceptions of professional mental health treatment among Australian Muslims. Table 6.3 presents survey responses to items gauging attitudes towards mental health services.

Table 6.3. Survey participants' perception of mental health services (*N*=200)

Survey Item	Response	*n* (%)
Counselling and psychological services can be beneficial for Muslims	Strongly Agree	121 (60.5%)
	Agree	74 (37.0%)
	Disagree	3 (1.5%)
	Strongly Disagree	2 (1.0%)
Muslims should try to deal with their problems within their own community without seeking help from counsellors/psychologists	Strongly Agree	5 (2.5%)
	Agree	10 (5.0%)
	Disagree	99 (49.5%)
	Strongly Disagree	86 (43.0%)
It is not appropriate for Muslims to seek help from counsellors/psychologists	Strongly Agree	9 (4.5%)
	Agree	10 (5.0%)
	Disagree	64 (32.0%)
	Strongly Disagree	117 (58.5%)
I would consider seeking help from a counsellor or psychologist in the future	Strongly Agree	41 (20.5%)
	Agree	112 (56.0%)
	Disagree	40 (20.0%)
	Strongly Disagree	7 (3.5%)

As shown in Table 6.3, 97.5% of respondents were of the view that counselling and psychological services can be beneficial for Muslims. Most respondents also disagreed that Muslims should deal with their problems within their communities without seeking help from

professionals. Additionally, the majority of respondents (*n* = 153; 76.5%) expressed a willingness to consider seeking help from a counsellor or psychologist in the future.

The comments provided by survey respondents elaborated on the positive perceptions. For example, Respondent 79 wrote, "[Counselling] can be beneficial to all people as some just need a person to talk to and help with their problems." Respondent 42 reflected, "I think it's easier to talk to a counsellor than to family members sometimes, as you know you won't be judged by professionals." Finally, Respondent 154 commented, "We all need an external unbiased but knowledgeable individual to give us insight into our troubles."

Similar to the Australian interview participants, the survey respondents expressed the view that seeking mental health treatment is consistent with Islamic values. Respondent 165 observed, "I completely understand that we rely on Allah and believe and accept His decree. There is nothing wrong with going to counselling and getting advice and help." Respondent 173 asserted,

> Being healthy is strongly encouraged in Islam. Mental health is a very important aspect of health and being healthy means being mentally healthy as well, not only physically. With the increased rate of mental illness, it is important for Muslims to keep mentally healthy - even if it means through counselling.

Respondent 171 commented that Islamic teachings encourage help-seeking for all problems. He stated,

> For the same reason that we require doctors' services when we are sick, the Holy Quran tells us that when we need help in anything we should go to those who know. Those with mental disorders are ones who are sick and should therefore go to the appropriate doctors, the psychologists/psychiatrists/ counsellors.

These comments reflect favourable views regarding a range of mental health services among Australian Muslims. Even so, it is noteworthy that close to 1 in 5 of the survey participants would not consider such help (see Table 6.3). Indeed, concerns about accessing mental health services were identified.

Accessing Mental Health Services: Barriers

As depicted in Figure 6.1, a range of barriers to accessing mental health services were evident in the data. Some of the issues which emerged included shame and stigma about accessing treatment, concern about the cultural and religious appropriateness of treatment approaches and fear about accessing treatment.

Stigma associated with mental illness. Across the data, a common issue was the community stigma attached to mental illness, resulting in a sense of shame and reluctance to access treatment. Participants observed that in their communities, mental illness is often associated with being *crazy* and therefore people with mental illness are unable to manage their problems. As a result of this stigma, there were issues acknowledging mental health problems and accepting the need for treatment. The participants' perceptions of the extent to which stigma is a problem in their communities varied. For 15 of the 20 Australian interview participants, stigma was seen to be problematic because it was attached not only to the individual requiring treatment, but also to their families. This reluctance was highlighted by Ali when he stated:

> I probably still have that misconception that going to see a counsellor convinces you that you're not a 100% ... within this community we have this misconception that going to seek counselling services that it must be a major issue.

This was echoed by Mahmoud, who observed, “We think going to psychologists, going to counsellors is actually a bad thing ... that's why they don't go seek help because they see it as shameful.” Rana reflected that when diagnosed with anxiety, she struggled with the notion that she needed mental health treatment. She had perceived that such services are only for people with severe mental illness: “When the doctor said to me to see a psychologist it did throw me out a bit 'cause I'm thinking, I'm not insane, I am a normal, everyday person.” Rana was then concerned about her family's judgments because “seeing a psychologist means you're mentally losing it.”

The stigma attached to mental illness was more pronounced among the Indonesian and Jordanian participants. Here the negativity was considered a major barrier to seeking help from mental health professionals. Indonesian participant Dina commented: "Just one word, they're crazy. They're not befriended, they are the one to be isolated ... that's how they consider people with mental illness." These comments highlight the social ramifications of being labelled with a mental illness. Dina observed in her voluntary work that parents of children with Autistic Spectrum Disorder are averse to seeking professional treatment, even if they can afford it. She stated that, "I still find some parents who were educated, who were wealthy and they know that their child is [Autistic] and are ashamed to go to a doctor for treatment."

The labelling of an individual with mental health difficulties as "crazy", or severely unwell, was also evident in the Jordanian data. Like the Indonesian participants, the Jordanians were concerned that having a mental illness could lead to social isolation. According to Amal,

> Unfortunately, the stereotype is like these people are retarded, you know, they are maybe dangerous at some point, you don't want to be near them ... unfortunately when you say the word mental health in this culture people will just think of the word crazy ... you just want to keep the kids away from these people.

Jordanian participant Maha commented that she had wanted to access counselling treatment following the breakdown of her marriage. She described feeling depressed during this time. However, her friends and family attempted to dissuade her from seeking professional help. She explained,

> At some point of my life I thought that I could use talking to someone but I had so many pieces of advice that you never should talk about this because people tend to have the stereotype image about these kinds of things in a bad way so we don't really think about it ... But I think everyone needs it, and I have to be honest, a lot of people tend to turn to Allah or turn to religion as the best way to get help.

Maha accessed counselling from a psychologist for a brief period, but the lack of support from her family made it difficult, particularly comments from her brother suggesting that accessing professional help meant that she was "crazy".

The stigma attached to mental health difficulties was less pronounced in the Australian than in the Indonesian and Jordanian samples. Furthermore, the level of stigma in the Australian Muslim community varied due to the influence of culture, acculturation, upbringing and education. Australian participant Layla explained, "Culture wise, I think people [who] come from overseas I think they've got stigma attached to health professionals ... they probably have the attitude where you have to soldier on and you don't go to a counsellor." Amir had migrated to Australia as an adult, and he acknowledged that influences from his cultural background contributed to his reluctance to access mental health services. He explained that,

> I have the idea from my background culture that this is not the proper way to do … not to go to someone else who you don't know just to give your secrets and expose your life to that person, which is not proper … You're putting yourself down when you do so. I wouldn't be comfortable doing so.

Other participants noted that Muslims who are born and raised in Australia tend to be more open to accessing mental health services. As Ali observed, "I think generally speaking, those that are brought up here in Australia and brought up within this culture ... and are educated, they will definitely understand the benefits of seeking counselling, as opposed to the older generation." Amira similarly observed that the level of acculturation impacts upon attitudes towards seeking mental health treatment. She stated, "The younger generation ... I think they've become more open minded and that they're accepting to these things, they'll go [and access mental health services] if they need it."

In regard to the survey data, although not pronounced, issues of stigma were evident (see Table 6.4).

Table 6.4. Survey participants' perceptions of accessing mental health services (*N*= 200)

Survey Item	Response	*n* (%)
I would feel embarrassed to access services with a counsellor / psychologist	Strongly Agree	4 (2.0%)
	Agree	33 (16.5%)
	Disagree	107 (53.5%)
	Strongly Disagree	56 (28.0%)
Most of my family members would be embarrassed to discuss their mental health problems with a counsellor / psychologist	Strongly Agree	24 (12.0%)
	Agree	76 (38.0%)
	Disagree	75 (37.5%)
	Strongly Disagree	25 (12.5%)
My family would approve of me accessing services with a counsellor / psychologist	Strongly Agree	53 (26.5%)
	Agree	108 (54.0%)
	Disagree	35 (17.5%)
	Strongly Disagree	4 (2.0%)

As shown in Table 6.4, the majority of respondents (*n* = 163; 81.5%) disagreed that they would feel embarrassed about accessing services with a counsellor or psychologist. In addition, most (over 80%) agreed that their family members would approve of them accessing mental health services. However, 50% of respondents were of the view that their family members would feel embarrassed to talk about their mental health difficulties with a professional. Such data indicates some inconsistency in the extent to which shame is attached to accessing professional help among the Australian Muslim community.

Concern regarding providers' perceptions of Muslims and Islam. A barrier that emerged from the Australian data was concern about the provider's ability to offer religiously and culturally appropriate treatment. As Hanan explained, "They don't understand things from a Muslim's perspective, it's very much a Western perspective with Western solutions. I don't feel it's catered for us." She observed that, "I think a lot of people [in the Muslim community] have wanted to [access services] but they just think it's not for them, they don't think they're going to get what they need from it."

A total of 13 of the 20 Australian interview participants stated that they were concerned about mental health practitioners' perception of practising Muslims. They commented that Islam and Muslims are viewed negatively in the broader Australian society. This was largely seen to occur as a result of the adverse media portrayal of local and international events involving Muslims, and public discussion regarding the incompatibility of Muslims living in Australian society. In this context, participants stated that they feared mental health service providers would view Muslims according to the same negative stereotypes. Amin observed that "ignorance exists in society about Muslims and they believe what they hear, so it funnels through everything, whether it's mental service, doctors, teachers, sports." As Mahmoud indicated:

> We've got a lot of misconception of Muslims being terrorists due to the subliminal messages that we get from the media, the propaganda and so forth. Usually most non-Muslims have this perspective of Muslims becoming terrorists, so this is going to automatically affect how the mainstream psychologist actually looks at the Muslim client ... this may not be conscious, this may be sub-conscious.

Other participants echoed these fears of negative judgments regarding their beliefs and practices. Imran noted that "If [a Muslim] is going to go to a counsellor they will think ... oh well these Muslims, what they talk and what they do is stupid." Similarly**,** Mahmoud commented:

> The client's going to keep thinking at the back of their mind, this person may be perceiving me as a terrorist. So, the client's going to always be fighting that thought in their mind.

Female participants discussed stereotypes about Muslim women and explained that practitioners tend to view practising Muslim women as oppressed. According to Sameera and Kareema, these concerns can deter Muslim women from accessing services. Sameera stated, "I know the stereotypes, I know the minute you walk in with the scarf, straight away, she doesn't know anything". Similarly, Kareema noted,

> I think they have this perception of us that we are sheltered women and our husbands make us do whatever they want ... we don't have a mind. So I think that is a huge fear going to a non-Muslim psychologist.

Tasneem and Sameera feared that practitioners would view Islam as the cause of their problems. For Sameera, “There is the idea that Islam is a religion which oppresses women so the doctors think a lot of your psychological problems are because of your religion.” Tasneem commented, “I think the non-Muslim community believes that a lot of the Muslim women have mental issues related to our religion. Maybe they think our religion is causing the mental issues so our religion can't solve it.” Similar issues were evident from the survey data as indicated in Table 6.5.

Table 6.5. Survey participants' perceptions of non-Muslim practitioners (*N*= 200)

Survey Item	Response	*n* (%)
Non-Muslim counsellors/psychologists do not understand emotional/psychological problems from Muslims' perspectives	Strongly Agree	30 (15.0%)
	Agree	70 (35.0%)
	Disagree	84 (42.0%)
	Strongly Disagree	16 (8.0%)
I believe that non-Muslim counsellors/psychologists may have biased or stereotypical attitudes towards Muslims	Strongly Agree	20 (10.0%)
	Agree	102 (51.0%)
	Disagree	67 (33.5%)
	Strongly Disagree	11 (5.5%)

As shown in Table 6.5, half of the respondents were of the view that non-Muslim counsellors and psychologists do not have a good understanding of Muslims' problems. Further to this, 61% agreed that mental health practitioners can have biased or stereotypical attitudes towards Muslims. These concerns were noted in their comments. For example, Respondent 23 stated, "Muslim counsellors are aware of the boundaries and lifestyles in a Muslim's life. Non-Muslims ... may perceive our lifestyle as oppressive, and encourage things that are not appropriate."

Not all participants were concerned about the perceptions of service providers. Rana observed that, "I think they have to be fairly professional because they have to deal with all sorts of people from all backgrounds." Rayann also considered that professionals would be aware of differing religious and cultural issues. "I'd like to think they'd be educated enough to understand the religious and cultural background. I'd like to think that every person in a profession is seeking knowledge to deal with the increasing Islamic population." Not surprisingly, this was not an issue in the Indonesian and Jordanian interviews as the participants were part of the majority culture and religion.

Worries about the treatment process. Another barrier consisted of a range of worries in regard to engaging with mental health services. Several participants feared that practitioners would steer them away from their religious beliefs and values. Nadia observed that some Muslims "are scared of the word *counsellor* because they think a counsellor is someone who is going to tell them what to do, tell them what they're doing is wrong, how they should do it." Ali echoed this fear. "One of the main concerns is that they could influence you ... they may have different ideals, different values to what a Muslim may have." Kareema noted that this was particularly concerning for Muslim parents. "We have our boundaries Islamically so if they're going to see a non-Muslim health professional they could be advised something very contradictory to what we're trying to teach [the youth]." When asked about her willingness to access mental health services, Hidaya replied, "I've heard they encourage things that steer them away from Islam." This was reflected in findings from the survey (see Table 6.6). As indicated in Table 6.6, over 60% of respondents were of the view that non-Muslim counsellors or psychologists may encourage Muslims to adopt solutions which are against Islam.

Table 6.6. Survey respondents' concerns of un-Islamic treatment approaches (*N*= 200)

Survey Item	Response	*n*	(%)
I believe that non-Muslim counsellors/psychologists may encourage Muslims clients to adopt solutions which are against Islam	Strongly Agree	20	(10.0%)
	Agree	102	(51.0%)
	Disagree	67	(33.5%)
	Strongly Disagree	11	(5.5%)

Other worries were raised by participants about engaging in treatment, regardless of whether or not the practitioner was a Muslim. Participants feared the use of medication and the prospect of hospitalisation. Rana discussed her uncertainty before engaging in treatment with a psychologist, which included:

> Not knowing what was happening, how they were going to approach me, deal with my situation, if they were going to be fully understanding, if they were going to judge me for what I've been through, just not knowing how they're going to take it.

Sameera identified a pervasive fear that, "... if they know that I'm sick maybe they're going to take my kids away, that's the idea." She also observed, "There is the fear from medication, they feel like any mental health issues needs medical intervention." Amira recalled her apprehension about accessing mental health treatment. "I was really afraid that I was going to be labelled as crazy, but it was either get help or just live in this mental horror." Although Amira subsequently engaged in treatment with a Muslim psychologist, her fears prevented her from being completely open. "I was worried about medication, I was worried about mental institutions, I was scared about those things so I said I'm not going to fully tell her everything about what I'm facing." For some participants, the fears associated with mental health treatment resulted in them delaying, or avoiding engagement with professional mental health services.

Religious perspectives as barriers to treatment. Although participants highlighted the beneficial aspects of faith on their mental health and coping, as presented in Chapter 4, some observed that an over-emphasis on certain religious beliefs could be counter-

productive. These beliefs were at times propagated within the Muslim community through Islamic lectures and discussions. This included the notion that mental illness may be a result of a weakness of faith which could be disheartening. In this regard, Amira commented,

> It would make that person feel helpless and hopeless. I could imagine that would be quite devastating, you feel like, okay well what hope do I have now? I'm dealing with this and I don't have any faith, then what am I supposed to turn to?

Similarly, Rana explained that when she was referred to a psychologist for anxiety,

> My mum first of all pointed out that I have a lack of *iman* [faith] and that ... really put me down a bit, my self-esteem. Then just having to realise that, alright, everyone has a different opinion but that's not necessarily the right opinion, that I have to do what's right for me.

According to the participants, mental health symptoms may be attributed to supernatural phenomena as the sole explanation for one's difficulties. As Hidaya explained:

> With something like post-natal depression, you'll find that women straight away say, it's the evil eye: because I had a baby people are giving me negative energy. They will never think of going to a doctor.

Such a perspective could cause sufferers to mental health problems to be discouraged from seeking treatment. Sameera observed, "That's why they feel like we don't need to go to a doctor, we need to go to a sheikh, a religious person to help us to get rid of this." Similarly, Jordanian participant Maha cautioned:

> The first thing they do they don't really take him to a psychologist or like see someone to help him, they see a sheikh, just to read Quran for him to help, to get this *jinnee* [spirit] out of him. I do believe that most the time it's not really right, it's not the reason, I think it's for other reasons.

The participants recommended that there be a balance between religious and secular perspectives of mental illness. This would enable Muslims to draw on the beneficial aspects of their faith to cope while leaving them open to the possibility of accessing professional mental health treatment.

Language as a barrier. Lastly, participants observed that for migrants to Australia, difficulties with the English language can serve as a barrier to accessing mental health

treatment. Hanan referred to her mother's difficulties migrating to Australia as an adult. Despite experiencing great distress, she had avoided accessing services. Hanan commented that her mother had been unable to find mental health professionals who could speak her language and understand her experiences.

> My mum didn't get help, because she was referred to the psychologist who don't get that they're married for almost forty years, and she's had seven kids, her life has been tough, she's illiterate, they don't get where she came from, they don't speak her language.

Amir and Mahmoud explained that although they were reasonably fluent in spoken English, it was a struggle to express the nuances of their internal experience. Amir noted that, "When you talk about your problems you really need someone who understands the background of your religion, your culture as well as your language because you can express in your language which you cannot express with another language." Similarly, Marwan stated:

> English is my second language, how can I explain what's inside, I can't, my English is not good enough to tell you what I feel, some of the words I don't know … I can't say it in English.

Mahmoud observed that in overcoming such barriers, it was important to have psychologists who speak the language of the community. "To explain a mental problem, you're going to have to be able to speak to that person in their language." Such comments highlight a need for access to practitioners who not only have an understanding of religious and cultural issues, but also who speak the language of community members.

Choosing a Mental Health Practitioner

Despite the barriers, the Australian participants generally expressed greater willingness to seek professional support than the Indonesian and Jordanian participants and had more opportunities to access mental health services. For the Australians, an issue was whether to seek assistance from either a Muslim or non-Muslim mental health practitioner (see Figure 6.1).

Preference for a Muslim mental health practitioner. Generally, participants preferred to access services with a Muslim practitioner as they felt that their religious beliefs and practices would be understood. Participants believed that this understanding would enable the practitioner to tailor treatment appropriately resulting in better outcomes. Australian participant Layla observed, "I'd prefer to go to a Muslim because they have a bit more understanding of our background and they could deal with us better." Nadia asserted that:

> Ideally it would be great to have a Muslim provider who understands your beliefs because they've got the same ones, who understands there are different levels of practising the religion and they're not there to judge you.

Also, Amira explained the importance of having treatment which is consistent with her beliefs:

> I tried my best to find Muslims because I felt more comfortable. If I'm using Islamic terminology they know what I'm saying and if I'm referring to some things in my life, we've got something to relate to. They can give me an Islamic perspective as well and I felt more comfortable, I felt like I trusted more.

Australian participants noted that an awareness of beliefs relating to supernatural phenomena was an advantage. Mahmoud observed that it was comforting to know that a Muslim practitioner would understand these beliefs in relation to mental illness: "We see linking things to the paranormal as a part of faith. A Muslim psychologist understands this point will also comfort Muslims because there's something in common there." Rana commented that she would feel uncomfortable discussing beliefs in supernatural phenomena with a non-Muslim practitioner. She stated, "It would just be foreign for them, they would not get what I'm talking about." Rana explained that she accessed services with a Muslim psychologist and found it helpful to have her beliefs understood:

> She [the psychologist] acknowledged that there could be other things that could trigger unhelpful thoughts. Acknowledging there is more than just what we know in everyday life ... there is the 'unseen' [i.e., supernatural phenomena] which in Islam we believe.

Another advantage to seeking services with a Muslim practitioner was the expectation that relevant religious and cultural concepts would not need to be explained, which may be time consuming and disrupt the flow of counselling. Hidaya observed, "To explain everything in Islam, if it does deal with your personal affairs to that extent, they'll obviously ask you why, you have to explain. Whereas with a Muslim counsellor you wouldn't have to explain it." Amir commented,

> If the psychologist is not Muslim it's too hard to explain [my beliefs]. If he's a Muslim, even not practising, he may understand most of what I'm talking about. He's coming from the same religion or background is really important because he will understand.

Whilst the interview participants preferred to seek services with Muslim practitioners, they noted that this option was not always available. Australian participants Layla and Hanan observed that there is a dearth of Muslim mental health practitioners, particularly those that specialise in complex areas of mental illness.

The views expressed by the interview participants in relation to accessing Muslim mental health practitioners were confirmed by the survey data (see Table 6.7).

Table 6.7. Survey participants' preference for a Muslim counsellor or psychologist (*N*= 200)

Survey Item	Response	*n*	(%)
It would make no difference to me whether a counsellor/psychologist is a Muslim or non-Muslim	Strongly Agree	19	(9.5%)
	Agree	40	20.0%)
	Disagree	94	(47.0%)
	Strongly Disagree	47	(23.5%)
I would only seek services from a counsellor/psychologist if he/she were Muslim	Strongly Agree	38	(19.0%)
	Agree	52	(26.0%)
	Disagree	90	(45.0%)
	Strongly Disagree	20	(10.0%)
There are not enough qualified Muslim counsellors/psychologists to assist the Muslim community.	Strongly Agree	99	(49.5%)
	Agree	75	(37.5%)
	Disagree	21	(10.5%)
	Strongly Disagree	5	(2.5%)

From Table 6.7 it is apparent that almost half (45%) of the respondents would only seek mental health services from a Muslim counsellor/psychologist. As Respondent 25 explained,

> I believe practising Muslim professionals have a better understanding of the context in which Muslims live and their day to day problems. Therefore, a Muslim practitioner could be of more benefit to the patient. Also, if the professional is knowledgeable about Islam, they can offer Islamic remedies for mental illnesses and personal problems they may be suffering.

Similar to the interview participants, the survey respondents largely agreed (87%; $n = 174$) that more Muslim mental health practitioners were needed to support the Australian Muslim community. In this regard, Respondent 54 commented that the limited number of Muslim practitioners meant that it may not be possible to find one who is compatible in terms of manner or approach.

> Even though I have been to both [Muslim and non-Muslim practitioners], the problem is that there aren't many Muslim practitioners. And from them, you still need to choose someone that would click with you and use the methodology that would suit the individual.

Preference for a non-Muslim mental health practitioner. Along with the advantages, a range of disadvantages were identified in accessing assistance from a Muslim mental health practitioner. These included a fear of contact outside the context of treatment due to the relatively small size of the Muslim community in Australia. Australian interview participant Amira accessed help from a Muslim psychologist. Through her treatment experience, she identified some troubling issues. She reflected, "You start feeling a bit uncomfortable, the fact that I see you in the community and now you have my file." Additionally, she noted that it was possible to see other Muslims she knew attending the same clinic. "One negative thing is that you're going there knowing that there's possibly other Muslims there and other people who may know you." She observed that she could understand that Muslims may prefer to seek help from non-Muslim practitioners where there would be greater anonymity. These concerns were also evident in the survey data, as shown in Table 6.8.

Table 6.8. Survey participants' concerns for confidentiality with Muslim mental health practitioners (*N*=200)

Survey Item	Response	*n*	(%)
I would be concerned about confidentiality with a Muslim counsellor/psychologist	Strongly Agree	17	(8.5%)
	Agree	38	(19.0%)
	Disagree	91	(45.5%)
	Strongly Disagree	54	(27.0%)

Whilst participants did not necessarily fear breaches of confidentiality regarding personal information, there were concerns about contact with a Muslim mental health professional in the community. Therefore, some participants preferred to see a non-Muslim. As Respondent 11 stated, "I think confidentiality is a major issue and people would feel very conscious of bumping into people at mosques and lectures since it's a small community." Respondent 159 was concerned about meeting a Muslim mental health practitioner at community functions. He stated,

> A really big concern is running into these counsellors in a Muslim gathering such as a Friday or *Eid* prayer or a Muslim function of some sort. And Muslims have a lot of these congregations, especially men! You do not want to socialise with someone who knows all your issues and problems. It would be very awkward. You do not expect to see your counsellor except professionally and don't want any increased chances of running into them at a gathering.

Therefore, the decision to engage with either a Muslim or a non-Muslim depended on a range of considerations. Respondent 114 noted that:

> There is always a fear that if the person is Muslim they will either a) be judgemental, b) not uphold confidentiality. However, there is a common ground and hopefully 'language' and understandings e.g. Allah, *Jannah* [paradise], etc. However, there is a perceived degree of anonymity that comes with a non-Muslim counsellor. It very much for me depends on the issues being discussed.

The preference for a Muslim practitioner also depended on whether religious knowledge was deemed to be relevant to the problem for which help was being sought. Respondent 8 wrote, "Depends on the issue, though a knowledge or understanding of the religion may be necessary, especially where it may relate to marriage and family." Other respondents

commented that certain problems require specialist knowledge and therefore seeking help from someone with particular expertise would take precedence over knowledge of faith practices and cultural issues. Respondent 115 commented,

> [The] main consideration would be how good the counsellor is, then whether or not they are Muslim might come into it. I think I would just feel more comfortable knowing that the person also values those ethos and morals I hold dear about my faith system and can guide and advise accordingly.

Respondent 127 commented on weighing the advantages between shared beliefs with the practitioner and their level of skill and experience.

> I think it's human nature to feel more comfortable with people that have similar perspectives or hold similar views, having a Muslim counsellor would be beneficial in that they can assist a patient with offering them advice based on their similar experiences and can relate to them more. That being said, it is also important to keep in mind the experience of the counsellor and the level of religious conviction, for example, if a counsellor is very knowledgeable in Islam but has no counselling experience, it might be preferable to see another more experienced counsellor regardless of their religious affiliation.

For some respondents, religious affiliation was not a consideration in seeking treatment, such as Respondent 42: "As long as the counsellor is capable of providing the services, I don't think religion matters that much." Similarly, Respondent 171 stated, "I am of the opinion that the ability of the practitioner should rule over his/her religion or nationality." Respondent 126 stated:

> It is a good thing to have the understanding of the religion and culture in order to guide you on what solutions are okay and available. But at the same time, I think if the counsellor is understanding, not critical and has no misconception of your religion then I don't see a problem with it.

The data reveal that for Muslims deciding to access professional treatment, there are a range of issues that have the potential to complicate the help-seeking process. Accessing treatment from a Muslim practitioner was generally preferred, however this option raised concerns for the participants.

Experiences with Mental Health Services

The previous experience of participants with mental health services had a profound impact on their attitudes towards accessing services in the future. Table 6.9 shows the extent of contact interview participants had had with professional mental health services.

Table 6.9. Interview participants' contact with mental health services

Participants	Level of contact with mental health services	Issue	*N*
Australian Participants (*N* = 20)	No Contact		12
	Direct	Depression	6
		Anxiety	3
	Indirect	Advocacy	1
		Family member receiving service	1
	Engaged with a Muslim mental health professional		3
	Engaged with a non-Muslim mental health professional		4
Indonesian (*n* = 8) & Jordanian Participants (*n* = *6*)	No Contact		12
	Direct	Depression	1
	Indirect	Family member receiving service	1

Note: Some of the participants fell into more than one category.

From Table 6.9 it is apparent that more Australian interview participants had accessed services compared with the Indonesian and Jordanian samples. The most common type of contact for the Australian respondents was with a non-Muslim practitioner. This was reflected in the survey where 36% (n = 72) of participants had accessed mental health services and 12% (n = 24) had accessed services with a Muslim mental health practitioner.

Positive experiences. Positive treatment experiences left a favourable perception of mental health professionals which reinforced facilitators to accessing mental health services (as show in Figure 6.1). This included that the practitioner adopted a stance of respect for the participants' beliefs and practices, were aware of the significance of religion and culture in their lives, and showed an interest in the way religion related to their problems and possible solutions. Australian participant Nadia observed:

> I think you just trust the person more because they're taking an interest into something that's a very important part of your life, and I think that's the big thing ... so if that person appears to somewhat respect your decision to live and believe what you do, then you feel safe and you feel comfortable.

Layla noted that her oncologist was aware of the significance of Islam to her coping. She described the discussions with him about her mental health as helpful.

> He wasn't Muslim but he did know a lot about Islam, I could tell [because] he would use things like mentioning Allah and things like that ... I did feel at peace and I felt that helped … Especially the spiritual side of things that would help me get through my hardship and I need someone to provide that for me ... it's important.

Sameera similarly commented on the benefits of practitioners demonstrating an awareness of the prominent role of religion. She relayed her experience as a translator for a family whose son was engaged in treatment with a psychiatrist. Sameera commented that the psychiatrist was able to work effectively with the family due to his awareness of pertinent religious and cultural issues:

> He read about different cultures ... he understood beliefs about the supernatural ... he understood a lot of things about Islam even though he wasn't Muslim ... he was very respectful, very understanding.

Sameera also noted that he recognised the important role of the family in the patient's treatment and sought to involve them in the process. She stated, "He was involving the family every step of the way ... getting the family to help."

Rana found it comforting to access services with a Muslim practitioner who incorporated her religious perspectives into treatment. She noted, "Just knowing that I was able to get the right help from the right people from an Islamic point of view. That was for me more than anything the reassurance that I needed." Rana reflected that the experience shifted her attitudes towards mental health services and challenged her fear in accessing professional help. She stated that she now views counselling as "a way of getting help and it's a way of finding a solution, from being in a state of unwell to getting help. [It's] a sense of the comfort for me; it's a very good thing."

Indonesian participant Dina had engaged psychologists to help manage her son with Autism. She described the benefits of psychological treatment and considered this to be complementary to her religious coping responses. She stated, "While [accessing] the therapy I continue to pray consistently, continually. So, on one hand trying to seek help [for her son from psychologists] on the other continue to pray to Allah." Indonesian participant Nisa considered that a lack of experience and familiarity is a barrier to accessing services. She commented,

> Even in Indonesia if you give something for free even they might not accept it, because they don't understand the function, they don't understand the benefit of getting that help. So, more socialisation about psychology would be of great help for the society.

Jordanian participant Maha accessed professional services following the breakdown of her marriage. Due to the cost, Maha was not able to continue with the treatment, yet her experience left her with a positive attitude towards services. She asserted that despite the community stigma associated with mental illness, she would access treatment if it was more affordable in Jordan.

> I would go, believe me I would go and I wouldn't even care if people knew that I'm going, I don't care, I just want to be fine. And if someone thought bad about me, if someone thought that I'm crazy well I think when I go, inshallah [God willing], I will be fine then I will be able to prove to him that you are the crazy person, not me ... If I

> was in a position where I really needed to get any help I can just to go through it and to go out. So yeah, I would go without even thinking.

The survey respondents were asked to provide feedback regarding their experiences with mental health services. Some noted the benefits of accessing professional help, such as developing skills to effectively manage their mental health problems. Respondent 28 stated that, "we all need tools to improve the way we deal with situations in our life. I believe that counselling has taught me many life skills." Respondent 44 commented that counselling was: "Very helpful, it made me make changes in life. I am now focusing on the positives and stress less. It's great to know that there is help out there and that we are not alone." These survey respondents highlighted the positive impact of the practitioners' understanding of religious and cultural issues. Respondent 7 was pleased that religious beliefs and practices were acknowledged and integrated in treatment: "they could understand and guide under the Islamic perspective." Respondent 164 described feeling comfortable to explore her religious issues and concerns with a Muslim practitioner.

> Initially I felt it would make no difference. But when I went to a Muslim counsellor I felt more comfortable as I could explain things better to her, how I felt regarding my level/state of *iman* [faith]. She even suggested [to] me ways on how to get regular with my prayers.

Respondent 88 commented that she felt understood as the psychologist could relate to religious and cultural issues. She stated that the service was, "Helpful, as she is able to relate to the cultural and religious conflicts, in regards to my environment and family." Respondent 34 commented on his positive experiences with practitioners who showed an interest in Islam: "I saw several non-Muslim mental health professionals during my illness and they were excellent in their care and expertise. When they didn't know if something was [Islamically] relevant or acceptable then they asked me". Such comments emphasise the benefits of religious and cultural awareness, particularly in overcoming barriers for Muslims in attending mental health services.

Negative experiences. Participants also identified negative experiences which reinforced barriers to accessing mental health treatment (as depicted in Figure 6.1). These included that practitioners lacked awareness of pertinent cultural and religious issues, while deferring to stereotypes. Australian participant Hanan discussed her experience with a psychologist to address her depressive symptoms stemming from problems in her marriage. Hanan felt misunderstood and judged according to assumptions about Muslim women. She explained, "I think I was just viewed as an oppressed woman, like oh, she's wearing hijab, this is her issue ... it wasn't ... I felt like I was being saved rather than helped." As a result, Hanan did not believe that she was fully heard or understood:

> We had different minds, they were trying to save me ... this poor little Muslim girl who's oppressed ... whereas I was trying to say 'how am I going to get myself out of this situation and deal with that?', whereas their perspective was it's an overall problem, I was the problem, my culture was the problem, whereas it was really just an aspect of my life.

Hanan indicated that this lack of understanding led to a religiously and culturally inappropriate approach. She stated that the psychologist was, "thinking I'm some oppressed girl who needs to break free and take off her hijab and go live by herself in some apartment in the city. For me, these were unrealistic solutions." The experience left Hanan feeling bereft of support: "I felt so much more isolated because I was like, now I know I'm in this by myself because they have no clue what I'm going through." She emphasised that feeling misunderstood by her psychologist contributed to her reluctance to engage with professional mental health services in the future. As she stated, "I'm so burned that I'd never do it again, if I felt like I'd benefited even an ounce I would've gone back."

Sameera generalised from the treatment she received in a maternity ward to mental health services.

> There are big issues about stereotypes, not just with mental health, even with normal medical treatment ... I was shocked even in the maternity hospitals, in just day-to-day

> care. Just because I was wearing a scarf they assume I can't speak English. The care, the attitude towards me was horrible.

Due to this experience, Sameera was reluctant to engage with other professional treatment services, including mental health services, as she expected to face similar responses. Australian participant Nadia explained the impact of encountering mental health practitioners who had little awareness of relevant religious and cultural issues. Nadia was a carer for her husband who experienced paranoid delusions and was admitted to a psychiatric hospital. She found the interactions with the mental health practitioners to be highly stressful as a lack of basic knowledge of Islam and Muslims resulted in numerous misunderstandings. The experience left Nadia viewing mental health services negatively and she was subsequently reluctant to engage with practitioners.

Even so, Nadia later sought counselling with a private, non-Muslim psychologist for herself and this helped to shift her views. Although the experience was generally positive, Nadia found it frustrating to have to explain basic Islamic beliefs and practices, which detracted from the session. She explained, “I'm there to talk about and work out some of the issues of my past, and it took up some time of the session, that I was paying for, and I'm expecting to leave there with some thought.” Nevertheless, the psychologist's demonstration of respect and interest in Nadia’s religious beliefs had a positive impact. She stated, “I think there's a huge benefit of it, we need it, and I would definitely access it, and I have, for counselling for my daughter, for myself. I'm okay with them now.”

The survey respondents similarly considered that a lack of understanding of religious and cultural issues had a negative impact upon the effectiveness of the services. Respondent 22 consulted a mental health practitioner who was, "Not helpful at all, could not relate to my religious beliefs, or understand the roles and responsibilities, duties of individuals, or family

dynamics." Other respondents discussed negative treatment experiences. For example, Respondent 27 wrote that her experience of counselling was:

> Not helpful at all. I felt like I was being judged. I felt like it was a waste of time. I needed an Islamic point of view. I was encouraged to consider leaving my husband. They didn't understand me, my beliefs.

In a similar light, Respondent 57 wrote about a counsellor's perception of Muslim men:

> The last counsellor I saw was quite helpful, but I revealed that my husband was Muslim (I was not wearing the hijab at the time) and I felt that the counsellor made assumptions about the relationship, for example, that my husband could be physically violent towards me. I felt she was possibly affected by stereotypical ideas of Muslims, and that Muslim men hit their wives.

These negative treatment experiences left a lasting impression on the respondents. Other participants mentioned that they were careful about the personal information that they disclosed to the practitioner due to fears that this would reinforce negative stereotypes about Muslims. Respondent 54 reflected that,

> I found the psychologist somewhat helpful. However, I tried to be mindful of what I was saying to not let her have a bad view of Muslims; so I wasn't really talking about the main problem. If I brought up something that was valid to me, she would negate the need; not realising that it is fundamental to my faith and the family structure.

The lack of religious and cultural awareness of practitioners resulted in critical needs for clients not being recognised. When participants felt misunderstood this became a barrier to them accessing mental health services in the future.

Conclusion

This chapter explored the stages of help-seeking identified by participants and this was represented in a model of Muslims' Help-Seeking Pathways. A range of pertinent issues for Muslims' help-seeking choices and areas that require attention in order to meet the mental health needs of Muslims were identified. Initially, a general knowledge of mental health problems was considered essential in order for individuals to recognise their symptoms and the need for help. Respondents indicated that religious coping and spiritual treatment were

integral to their efforts to manage mental health problems. Religious leaders were described as playing an important role for Muslim communities in providing religious guidance to address personal difficulties. The family was identified as a primary source of advice and support, reflecting its central role for Muslims. Some participants expressed positive views regarding mental health services, yet they typically faced a range of significant barriers in accessing professional help. Furthermore, in Australia decisions to seek help from either a Muslim or a non-Muslim practitioner complicated the help-seeking process. Once mental health assistance had been accessed, these treatment experiences either challenged or reinforced the barriers. In instances where participants felt understood by the practitioner, this fostered a sense of safety and trust. On the other hand, experiences where practitioners lacked awareness of religious and cultural issues reinforced barriers to accessing services.

Overall, the data revealed the powerful impact of positive contact with mental health service providers in shifting barriers to accessing professional treatment. These findings highlight areas to challenge barriers for Muslims accessing professional mental health services. This includes the provision of religiously and culturally sensitive approaches. The following chapter identifies ways to engage Muslim clients in religiously and culturally sensitive treatment.

Chapter 7

Challenging Barriers to Accessing Mental Health Services:

Religiously and Culturally Sensitive Approaches for Muslim Clients

The previous chapter elucidated a range of issues for Muslims in responding to their mental health problems. This included commonly-used sources of help, such as religious and family supports. A range of barriers to accessing and engaging with professional mental health services was identified. Through the participants' experiences with treatment services, these barriers tended to be either challenged or reinforced. The participants' reflections on their experiences indicated that services which are sensitive to religious and cultural issues can help Muslims to overcome barriers to accessing treatment.

This chapter extends this discussion by focusing on the ways that practitioners can engage Australian Muslim clients in religiously and culturally appropriate treatment. As this chapter is based on reflections about treatment experiences, the findings were drawn from the Australian survey and interview data. The majority of participants from Indonesia and Jordan had not accessed professional treatment due to the lack of available services in these countries and the stigma attached to mental illness. Initially, the chapter outlines the participants' views regarding the need for mental health services in the Australian Muslim community. This is followed by aspects which participants considered to be essential in the provision of religiously and culturally appropriate treatment.

The Need for Mental Health Services for Muslims

All participants expressed concern about untreated mental health problems among the Australian Muslim community. In the survey, Respondent 13 observed that, "Muslims can and do suffer from difficulties and distress, just like everyone else does. I see too many people complaining about mental ill-health in the Muslim community." Respondent 32

commented, “Just looking around me so many of the Muslim youth are depressed ... not being able to talk to a professional, the actual problem becomes bigger.” Indeed, a large percentage (60%; *n* = 120) of the participants self-reported that they had experienced mental health problems (see Table 7.1) when asked about their history of mental illness.

Table 7.1. Survey participants' self-report of mental health problems (*N* = 200)

Mental Health Condition	*n* (%)
Depression	88 (44.0%)
Anxiety	74 (37.0%)
Bipolar Disorder	7 (3.5%)
Schizophrenia	4 (2.0%)
Personality Disorder	4 (2.0%)
Never Suffered Mental Health Problems	78 (39.0%)

Note: Some participants selected more than one mental health condition.

Most of survey respondents (94%; *n* = 191) indicated that an increase in mental health services for the Australian Muslim community is imperative (see Table 7.2).

Table 7.2. Survey participants' attitudes toward the need for services (*N* = 200)

Survey Item	Response	*n* (%)
The Muslim community needs more mental health support services	Strongly Agree	118 (58.0%)
	Agree	72 (36.0%)
	Disagree	11 (5.5%)
	Strongly Disagree	1 (0.5%)

As mentioned in Chapter 6, participants saw a need for information regarding treatment services in Australia for Muslims. In the interview, Bilal emphasised this as an issue, "... too many people do go through depression but they don't even know that ... you can cure this, there's a treatment ... they don't have enough knowledge about things like this". Likewise, Amir asserted that,

> There should be more of just letting people know what the service is about, maybe there are some good services, but a lot of people don't know about them. And a lot of people are scared of them as well and there's that perception in the community that going to a counsellor or something like that is for crazy people.

Considering the religious and cultural factors involved in Muslims' help-seeking processes, approaches which account for these issues are likely to challenge barriers to accessing professional treatment.

A Framework for Religiously and Culturally Competent Treatment

The main areas for religiously and culturally appropriate treatment approaches for Muslim clients as identified by the participants are represented in a framework (see Figure 7.1). In this framework two areas have been emphasised: the importance of underpinning knowledge, and the manner and treatment approach of the practitioner.

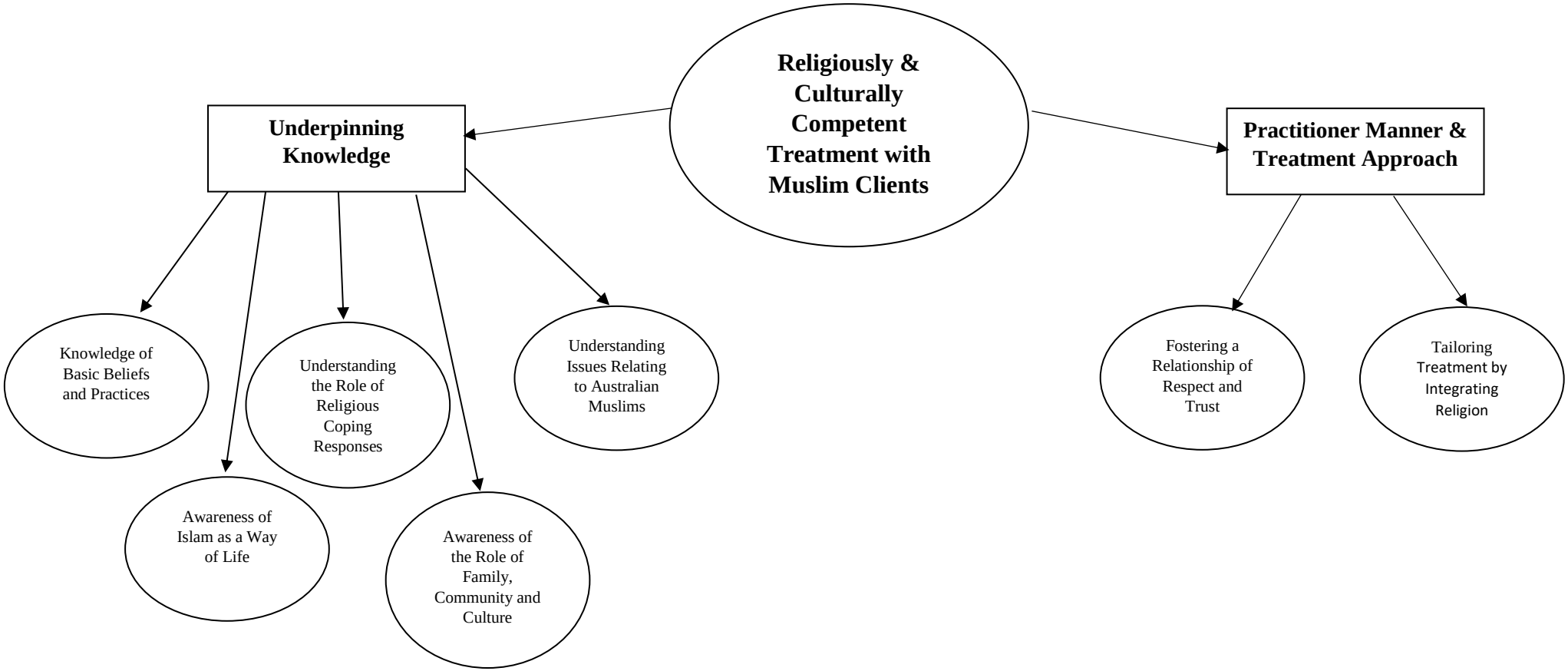

Figure 7.1. Framework for religiously and culturally appropriate treatment for Muslim clients

Underpinning Knowledge

It was recommended that practitioners possess specific knowledge of Islam in order to engage Muslim clients in treatment. Comprehending the profound role of religion was seen as necessary in order for practitioners to connect with Muslims. Australian interview participant Bilal commented on the usefulness of religious and cultural knowledge when working with Muslim clients, "It's having that different perspective, a little bit of background about the people that you're working with that could give you that benefit." The value of a practitioner having knowledge of Islam and Muslims was particularly evident in the survey data (see Table 7.3).

Table 7.3. Survey participants' attitudes regarding practitioner knowledge of Muslims and Islam (*N*= 200)

Survey Item	Response	*n*	(%)
It is important that non-Muslim counsellors / psychologists have some understanding of Islam when treating Muslim clients	Strongly Agree	110	(55.0%)
	Agree	70	(35.0%)
	Disagree	17	(8.5%)
	Strongly Disagree	3	(1.5%)
Counsellors / psychologists can provide effective services to Muslims through training about Muslims and the Islamic faith	Strongly Agree	65	(34%)
	Agree	98	(49%)
	Disagree	28	(14%)
	Strongly Disagree	6	(3.0%)

As shown in the Table 7.3, 90% of the survey respondents agreed that it is important for mental health practitioners to have some religious and cultural knowledge about Islam when engaging Muslims in treatment. As Respondent 25 commented:

> I think it could be difficult for the non-Muslim counsellors and psychologists to treat Muslims if they do not understand Islam and the Islamic way of life, as the Islamic culture plays a large role in practising and non-practising Muslims' lives.

Respondent 81 noted that a lack of knowledge of religious or cultural issues can hinder rapport with Muslim clients:

> In my professional role, I continuously come across [Muslim] people suffering from mental health issues. Most of my clients go to non-Muslim counsellors to seek advice. Most of these counsellors do not have enough knowledge about our religion and are not culturally sensitive which can make it difficult for my clients to build a relationship with the counsellor.

Five areas of knowledge were identified: knowledge of the basic beliefs and practices; awareness of Islam as a way of life; understanding the role of religious coping practices; awareness of the role of family, community and culture; and understanding issues relating to Australian Muslims.

Knowledge of the basic beliefs and practices. A basic knowledge of Islamic beliefs and practices was described as a gateway to understanding the belief system of Muslims. In the survey, Respondent 81 stated,

> By having knowledge about the Islamic values, it can make it easier for the counsellor to relate to the client. Also, they are in a better position to give advice which the client is most likely to take on board and listen.

This basic knowledge should include that Muslims believe in one God (Allah) and the prophets (e.g., Adam, Moses, Jesus, Muhammad), sacred books (e.g., the Quran), and supernatural phenomena such as angels, *jinn* and the hereafter. Other important information included the Islamic obligations in families and the general prohibitions. For example, Respondent 2 wrote: "Basic knowledge about religious practices (e.g., daily prayers, fasting etc.) would also be useful. The basic rules pertaining to any issue regarding what is allowed or acceptable for a Muslim and what is forbidden or disliked."

Participants noted that Muslims commonly see a distinction between culture and religion. Cultural factors were described as those attitudes or behaviours that come from ethnic or community influences, whereas religious factors are beliefs and practices based upon sacred texts. As Respondent 33 wrote, "Belief in Allah ... the world of *jinn* [spirits], angels, heaven and hell ... *sunnah* [way] of Prophet Muhammad, difference between cultural

and true Islam, what Islam prescribes as a cure... rights of women/men husband/wife, rights of children".

Awareness of Islam as a way of life. As outlined in Chapter 5, Islam is a way of life for the participants. The incorporation of religion in their lives was reflected in the dual functions of the sacred lens and compass, where the participants used religious guidance to perceive, understand, and respond to their experiences. An awareness of the integral role of Islam in Muslims' lives was deemed necessary for non-Muslims to understand the connection between religion and mental health. As Respondent 103 wrote, "Being a Muslim is a way of life. Islam is in every aspect of our daily life so it is very hard to separate your problems from Islam. Islam also has a way to ease people's pain and suffering." The incorporation of Islam in Muslims' lives has implications for the conceptualisation of mental health problems, coping options and treatment approaches. Therefore, an appreciation of Islam as an ever-present influence throughout Muslims' lives was deemed essential for practitioners to understand.

Understanding the role of religious coping responses. Chapter 5 provided an exploration of the ways in which the participants turn to faith perspectives and religious practices as an essential part of their coping. Therefore, the practitioners' understanding of Muslims' coping was considered to be a vital part of the therapy process. In the survey, Respondent 156 expressed the role of religious coping:

> My connection to God is the strongest supporter of my mental health. Islam has within it many practices and prayers that build and sustain the mental health. The repetition of these helps to reinforce the mental uprightness of a Muslim. If practised with correct understanding, they are very effective.

Practitioner knowledge of specific religious beliefs was encouraged. This included pre-destination, that good may arise from difficulties and that there is a deeper meaning for individual struggles. Also, to be familiar with religious coping practices such as prayer,

supplications (*du'a*) and reading the Quran. These were described as connecting Muslims to a deeper meaning for their personal problems and provide a sense of hope and optimism. As such, Muslims tend to draw upon religious coping responses for all kinds of personal problems and throughout all stages of their help-seeking processes. Practitioners who are aware of Muslims' religious coping responses were deemed to be more effective as they would be able to encourage their use.

Awareness of the role of family, community and culture. As discussed in Chapter 6, family and community are likely to have a prominent role for Muslims. Participants noted that these social systems influenced a range of areas in their lives, impacted their help-seeking process and the management of their mental health difficulties. Although these systems provide support, they can also present unique issues and challenges. As such, participants considered that it would be helpful for practitioners to be aware of the roles, expectations and responsibilities that exist within these systems. Furthermore, the obligations in families overlap with religious teachings and values. For example, the importance of the parental role was noted by Respondent 154, "our parents play an important role in our lives and we aim to please them" and she wanted practitioners to know that "any solution that - involves abandoning or severing ties with family is not acceptable." Similarly, Respondent 29 commented that practitioners need to be aware of "The strength of family and social ties in Muslim communities, and to consider the need for strong social bonds during assessment and treatment."

In terms of cultural influences, Respondent 2 noted that it would be helpful for practitioners to understand the diversity of Muslims in Australia:

> Knowledge of the different cultural beliefs within the Muslim community itself. Since Muslims come from all countries and all corners of the Earth, the counsellor has to have some appreciation of the cultural/education/etc. variety with the Muslim

> community, and especially the cultures which are more dominant in Australia, for example, the Lebanese and Turkish cultures in Melbourne.

Respondent 135 commented that cultural influences need to be considered when treating Muslim clients. She noted that these can differ substantially from common expectations in a westernised society. She explained,

> For me personally, it isn't necessarily the things that I think are Islam-specific, but more things that are culturally specific. For example, if I felt suffocated at home with my parents at my age (over 25 years), and discussed issues of wanting to explore my life's opportunities more, not wanting to waste my life doing nothing, etc. - a potential solution from a non-understanding professional may be to "pursue my dreams", move away, etc. etc., which are completely culturally inappropriate for me.

This points to the complex nature of broader social systems, revealing that family, community and culture can be both a source of support and a cause of stress and tension in coping with mental health concerns. Clearly, practitioners need to consider strategies and approaches that are consistent with cultural values. This suggests that a broader, contextual understanding of Muslim clients is useful in order to gain a comprehensive picture of their circumstances and needs in relation to their problems. In this regard, Respondent 115 stated,

> As long as the more systemic, person-in-environment approach is taken. Muslims are often weighed down by spiritual, cultural and societal constructs and find it difficult to map themselves out during times of stress in relation to this. It can't just be a psychological approach working on thoughts and the brain, or a societal approach working on just the environment. Counselling Muslims must address culture, family, family of origin, spirituality, understandings of gender, understandings of religion, societal environment, personal understandings of self, etc.

In summary, in order to engage Muslim clients, it is necessary that practitioners convey an awareness of the complex influences of family, community and culture.

Understanding socio-political issues for Australian Muslims. The data shed light upon the impact of the current socio-political context on Australian Muslims' willingness to seek professional help. The interview and survey participants referred to the stress of being Muslim in a climate where Islam is often associated with extremism and terrorism through political and media discourse. Participants opined that Muslims and Islam are commonly

misunderstood as they are viewed according to negative, stereotypical assumptions. As outlined by Respondent 2:

> An understanding of the political issues and the socio-political context pertaining to Muslims who live in non-Muslim societies is also important as this would help the counsellor understand and appreciate the struggles we are going through which do affect both adults and children alike in our community.

Respondent 111 was concerned about the societal perception of Islam and Muslims and suggested that practitioners be aware, "What it's like to live in a country where Islam is looked down upon - we are all human beings regardless of religion and should not be treated any differently."

Participants noted that practitioners needed to be aware of the range of concerns impacting Muslims, such determining their identity, war-related trauma, issues associated with migration, and adjustment difficulties. Whilst Muslim clients may be born and raised in Australia, they can be affected by these difficulties through the experiences of their families and community. Respondent 26 wrote:

> [Muslims] live in turmoil torn between their identity as Muslims and at the same time trying to fit in as Australians. Parents who were born overseas are not trying to change their way of thinking and adapting to an Australian way of life, hence this will negatively impact on their children's mental wellbeing, Muslims who came from war-torn countries [are] affected with the loss of dear ones or being tortured.

The interview data showed that young Muslims in particular can struggle to navigate a space between being a Muslim and a part of Australian society. As Sameera stated,

> There is a lot of young people who have an identity crisis between being a Muslim and being an Australian at the same time ... it causes a problem when you are acting somewhere in a different way at home to what you are outside.

Hidaya added,

> In a non-Muslim country, a lot of people go through identity crisis so they're just ... in limbo ... Like I was talking to one of my family friends and she's in year 7 and she's just like I don't know who I am, I hate school, she doesn't fit in...

These comments highlight the value of practitioners being aware of the range of complex stressors faced by Muslims living in Australia.

Another concern was for practitioners to avoid broad generalisations about Muslims. Respondent 34 commented that, "Just knowing that a patient is Muslim doesn't tell you everything you need to know, you need to get to know each patient as an individual." Similarly, Respondent 140 asserted that, "They [practitioners] should not be judgmental and not categorise all Muslims as one. Each Muslim is different in belief and practice … treat each client like any other client but respect their beliefs."

Practitioner Manner and Treatment Approach

A main concern that emerged was the need for practitioners to attend to their manner and approach when treating Muslim clients. It was recommended that practitioners be conscious of their assumptions about Muslims and Islam, and adopt a stance of curiosity and respect for their religious beliefs and values. These were described as the main elements of a trusting therapeutic relationship with Muslim clients.

Practitioner manner of curiosity and respect. The practitioner's manner was described as pivotal, particularly in regard to the way that they referred to their clients' religious beliefs. Due to the socio-political climate, the participants noted that they were very sensitive to negative comments about Muslims and Islam. They appreciated practitioners who demonstrated curiosity and respect for their beliefs, and such an attitude fostered trust. Interview participant Sameera reflected:

> You don't have to believe in everybody's culture or everybody's faith, just to respect them that's enough, then once you respect them you're going to get their trust and they will open up. But if from the get-go they can see that you're thinking of them as a lower class, you're thinking of them as stupid and ignorant, why would they open up to you, they won't.

Participants noted that they were offended by suggestions that Islam is flawed or the cause of their problems. Such intimations distanced Muslim clients from the practitioners. Sameera explained, "there is that stereotype at the start of it that your religion is actually really oppressing you, so it's causing psychological problems, that's the assumption." This assumption was seen to be deeply insulting and could alienate them from accessing professional treatment.

A positive experience was expressed by Australian participant Nadia in relation to the attitude of a male, non-Muslim psychologist toward her. He had demonstrated an interest in the significance of Islam in her life as a way of coping with her difficulties. She explained:

> I think you just trust the person more because they're taking an interest into something that's a very important part of your life, and I think that's the big thing ... so if that person appears to somewhat respect your decision to live and believe what you do, then you feel safe and you feel comfortable.

Consequently, Nadia was able to overcome her concern about accessing mental health treatment and work through her problems with professional support.

In summary, effective therapeutic engagement requires that practitioners are reflexive regarding Muslims and Islam and seek to understand and empathise with their clients' perspectives and experiences.

Tailoring treatment by integrating religion. Tailoring treatment approaches to accommodate Muslims' faith and religious practices was recommended throughout the Australian data. In the survey, most respondents (89%; *n* = 178) considered that for treatment to be effective for Muslim clients, incorporating their religious beliefs and practices was necessary (see Table 7.4).

Table 7.4. Survey participants' attitude toward combining religion with treatment (*N*= 200)

Survey Item	Response	*n* (%)
It is important to combine the spiritual and religious teachings of Islam with counselling treatment.	Strongly Agree	118 (59.0%)
	Agree	60 (30.0%)
	Disagree	20 (10.0%)
	Strongly Disagree	2 (1.0%)

Across the Australian samples, there was a clear perception that Islamic perspectives can be compatible with Western counselling approaches. For example, Respondent 135 asserted:

> I think that Islam actually has a lot to say about the importance of balanced mental health and wellbeing, and actually can guide us in situations where we may not feel at our "mental best". The teachings of Islam guide us on how to deal with times of adversity, and stress, and what to do when one feels alone, and thus this needs to be combined into treatment. Neither can really exist on its own.

According to the participants, practising Muslims would be more responsive to treatment processes that incorporate their religious perspectives and practices. As Amir asserted. "If [the practitioner] knows that the patient has great consideration for his religion he should use the religion as an entrance to his heart to understand and to deal with him." Similarly, Respondent 50 wrote,

> The counselling for a practising Muslim will be more successful if it combines the spiritual and religious teachings of Islam because that is the Muslim foundation to success. We can accept advice and information that is valid and helpful, but adding an Islamic perspective will help with the counselling process.

The data suggests that encouraging Muslims to draw upon religious coping responses is compatible with their religious views and assists them to manage their mental health problems in ways that are relevant and meaningful. Tailoring treatment in this way requires a level of skill on the part of the practitioner in order to incorporate religious beliefs and practices. This involves the practitioner being able to collaboratively explore with the client the religious beliefs that enhance their understanding and assist their responses to mental

health difficulties. The practitioner would then need to be able to sensitively and appropriately guide the client in drawing upon religious perspectives and coping practices that lead them towards their treatment goals.

It is noteworthy that a minority of survey respondents were cautious about the inclusion of faith in their mental health treatment. Respondent 35 commented that, "I believe that I have enough knowledge to be able to think through the Islamic perspective but right now I just need some neutral advice and then I will be able to tailor it Islamically." Respondent 42 observed that: "Counselling is not about spirituality or religion. Usually people seek counselling mainly of their mental state like depression. However, some religious values could be used. For example, suicide is not a solution." These comments highlight the importance of practitioners clarifying the preferences of their Muslim clients rather than assuming that faith must be included. Generally, incorporating religious and psychological approaches provides a holistic approach to treatment and would likely enhance Muslims' therapeutic engagement.

Conclusion

The participants viewed religiously and culturally sensitive treatments for Muslims as essential for their engagement with professional services. Their reflections provided the basis for a framework which outlined two main areas for religiously and culturally sensitive treatment: practitioner knowledge and practitioner manner and approach. Practitioner knowledge includes an awareness of the significance of Islam in Muslims' lives, basic Islamic beliefs and practices, religious coping responses, the primary influence of family and culture, and issues relevant to the Australian Muslim community such as the impact of the current social and political context. Practitioner manner and approach to treatment includes the

importance of developing a trusting therapeutic relationship through curiosity and respect, and a willingness to integrate Islamic beliefs and religious coping responses into treatment.

The findings show that the participants considered that faith and religious practices are intertwined with their good mental health, and provide positive ways to deal with their difficulties. Respondents asserted that the integration of Islamic perspectives and practices is likely to have a positive impact on treatment outcomes. Participants noted that increased understanding of Muslims' beliefs and practices would assist mental health professionals to engage Muslim clients in treatment, build rapport, and provide appropriate treatment interventions. In turn, Muslim clients are likely to perceive that they are understood by the practitioner and that the treatment is responsive to their needs. The following chapter provides a discussion of the thesis findings.

Chapter 8

Discussion

The previous chapter presented the third and final section of the results, outlining ways for practitioners to engage Muslim clients in treatment. This chapter provides a discussion of the research findings. A summary of the findings is presented followed by an examination of the main results in terms of previous research and existing theories. Subsequently, practical implications are identified along with ways to address a range of issues relevant to Muslims' mental health. Lastly, the strengths and limitations of the research are discussed, leading to recommendations for future investigations.

Summary of the Findings

The aim of this research was to "give voice" to practising Muslims with regard to their perceptions and experiences of mental health and illness and access to treatment services. Three main findings emerged from the qualitative and quantitative data. The first was that Islam served as a sacred lens and a sacred compass for the participants. That is, Islam provided the participants with a way to see and respond to all spheres of daily life, including their mental health. This means that for Muslims, religious perspectives provide a way to explain mental illness. Furthermore, religious beliefs and practices can offer valuable coping resources. The second main finding was that the participants adopted distinct help-seeking pathways. This was represented in a help-seeking model that identified the following stages: recognition and identification of mental health problems, initial problem management which included seeking help from family and religious leaders, barriers to accessing treatment and experiences of accessing mental health services. The final finding was that the participants required religiously and culturally sensitive treatment. That is, practitioners need

to have specific religious knowledge and attend carefully to the therapeutic relationship with Muslim clients, particularly in terms of building trust.

The Sacred Lens & Sacred Compass

"I'm trying to be aware that God is watching me at all times". This quote is from Australian interview participant Amir and reflects his consciousness of God in daily life. Accordingly, the participants described Islam as a holistic way of life which is incorporated in all areas of living, an observation that has also been made by previous researchers (e.g., Abdel-Khalek & Naceur, 2007; Abu Raiya, Pargament, Mahoney & Stein, 2008; Abu-Ras & Hosein, 2015; Ghorbani, Watson & Khan, 2007; Tiliouine, Cummins & Davern, 2009). In order to highlight the all-encompassing dual functions that Islam provided for the respondents, the concept of the sacred lens and sacred compass was established. The sacred lens assisted the participants to focus their attention and thinking on Islamic beliefs, teachings and values in their daily lives. The compass, on the other hand, was used to direct their choices and actions in line with religious teachings.

The adaptive influence of Islam was consistent across participants from the Muslim-majority and Muslim-minority samples. It is important to note that Muslims are not a homogenous community and this was reflected in the samples not only in terms of their country of residence but also in the range of ages, different levels of education, varied upbringing, diverse ethnicities, combination of languages spoken, varied cultural background, and different levels of acculturation. Despite this diversity, there was little variation in the emphasis that participants, all of whom were practising, placed on the significance of religion in their daily lives. They described Islam in similar terms as a belief and practice, in that it shaped their perspectives and guided their behaviours. Even so, they differed in their application of religious perspectives and behaviours. Reflecting these differences, some

participants emphasised being conscious to avoid prohibited activities, such as drinking alcohol or gambling, others talked of making efforts to control their anger or be polite and friendly in their interpersonal interactions, whereas others emphasised planning their daily activities around the prayer times or basing family decisions on Islamic guidance. Therefore, whilst the central role of Islam was consistent for the participants, this manifested in different ways.

The role of religion in the lives of Muslims is a fundamental concept as it has implications for understanding their perspective of mental health and illness, adaptive coping responses and appropriate treatment. Previous studies have confirmed the adaptive role of religion for coping and wellbeing (Gartner, et al., 1991; Pargament & Abu-Raiya, 2007; Pargament et al., 1998; Pargament et al., 1990; Salsman & Carlson, 2005). The findings from this research provide evidence that Muslims typically view their religiosity as a source of support and assistance for their mental health.

Religiosity was related to mental health in a number of ways. The participants across all three countries described adopting similar religious coping strategies which provided them with positive cognitive appraisals of adverse events. These adaptive responses assisted the participants to find meaning in their struggles and fostered feelings of optimism and hope, thereby reducing their emotional distress. Seeking God's help through prayer, making *du'a* (supplications) and reading the Quran gave participants a sense of support and connection to God. These helpful cognitive and behavioural responses assisted with the participants' overall positive affect which they explained was linked to maintaining good mental health.

Previous research has distinguished between extrinsic and intrinsic religiosity (Allport & Ross, 1967) in terms of mental health (e.g., Cohen & Hill, 2007; Donahue, 1985). According to Allport (1966), extrinsically religious individuals use their religion for self-

serving interests, such as monetary gain or social status. In contrast, people who are intrinsically religious live their religion through the internalisation of religious beliefs. That is, individuals who are intrinsically religious adhere to religion as a result of their own beliefs and convictions, rather than for external reasons. Religion is the main motivator in their life, to feel a divine presence and be privately religious (Allport, 1966). Intrinsic religiosity, unlike extrinsic religiosity, has been linked to desirable mental health outcomes (Berry & York, 2011; Jansen, Motley, & Hovey, 2010; Wood & Herbert, 2005) including with Muslim samples (Amer & Hovey, 2005; Parveen, Sandilya & Shafiq, 2014).

In this study, the participants' observation of a link between religion and good mental health might have been due to their high intrinsic religiosity. The participants described themselves as practising Islam suggesting that their faith is more internally than externally oriented. Therefore, it must be acknowledged that the reported positive influence of religiosity on mental health may not be generalisable to Muslims with low intrinsic religiosity. Before firm conclusions can be reached further investigations are required with Muslim participants that explore the relationship between various levels of intrinsic religiosity and mental health.

It is important to note that Allport's conceptualisation of religiosity is based on research involving Christian samples (Allport, 1966; Allport & Ross, 1967) and tends not to account for the ways in which religion can permeate Muslims' lives. The concept of the sacred lens and compass extends the description of intrinsic religiosity by accounting for the day-to-day integration of Islam as well as the evolving personal journeys of faith as described by the participants. That is, they continued to turn to the sacred lens and sacred compass to guide and shape their values, perspectives and actions, such that religion became an increasing part of their lives. The participants described exerting a conscious effort to incorporate religious guidance throughout their personal affairs, and this was seen as an

adaptive and central part of their personal growth. They regularly assessed their religiosity and at those times that they perceived that they were lacking, they described a process of reaffirming their faith and strengthening their religious practises.

The conceptualisation of the lens and the compass provides a focused way to define intrinsic religiosity when conducting research with Muslim samples. This could inform future exploration of Muslims' religiosity, particularly in regard to the implications for their coping and mental health. In terms of treatment, the conceptualisation of the lens and the compass may help practitioners to understand practising Muslims' internalisation of religion throughout daily life. This could be utilised to explore the ways that Muslim clients view their problems and identify responses that are consistent with their beliefs and values. The conceptualisation of the lens and compass can assist to identify religious struggles for Muslim clients, where there may be a discrepancy between their religious beliefs and values, and their choices or actions in response to their difficulties.

Religious perspectives on mental illness. For the participants, the sacred lens provided explanations for the aetiology of mental illness. This included that some mental illnesses are caused by weaknesses in faith or supernatural phenomena. As these beliefs were apparent across the Australian and international samples they appear to be informed predominantly by religious teachings rather than cultural influences. Such beliefs are drawn from the two main sources of religious knowledge in the Muslim world, the Quran and *hadeeth.* These Islamic texts make reference to the protective nature of faith and refer to beliefs in supernatural phenomena such as angels, spirits (*jinn),* the evil eye (*ayn*) and black magic (*sihr*).

Other studies have similarly observed that Muslims see a connection between religious beliefs and mental illness. Al-Adawi et al. (2002) reported supernatural views of

mental illness among Muslims in Oman and Eltaiba and Harries (2015) found that among Muslims suffering mental illness in Jordan, religious beliefs were central to their understanding of their condition. As one of the few studies conducted in the West, Weatherhead and Daiches (2010) reported that Muslims in the United Kingdom acknowledged both religious and secular perspectives of mental illness. Although the participants in the current research described their perspectives of mental illness and effective treatment as being distinct to mainstream models, they considered that aspects of these approaches could be complementary. That is, that their religious beliefs do not preclude them from accepting certain Western secular conceptualisations of causes of mental illness, such as experiencing stressful events, trauma, a lack of social support and interpersonal conflict. In this way, they considered that it was possible to bridge the gap between the distinct perspectives. Whilst this view was also apparent among the participants from Indonesia and Jordan, these participants noted that in their communities, secular perspectives of mental illness were seen to diverge from religious ones. This is not surprising, given the lack of available mental health services in these settings.

The participants from Australia, Indonesia and Jordan all emphasised strengthening their faith and religious practice and seeking religious guidance or spiritual healing (*ruq'iah*) as a way to deal with psychological and spiritual afflictions. Yet the participants also commented on the usefulness of mainstream psychological treatments to complement their religious responses. This view was particularly apparent among the Australian participants, suggesting that religious and secular perspectives of mental illness need not be mutually exclusive. Other studies indicate that Muslims in majority-Muslim societies regard certain Western treatment modalities to be consistent with their religious beliefs. For example, Naeem, Gobbi, Ayub, and Kingdon (2009) reported that among a sample of Muslim university students in Pakistan, the principles of CBT were considered to be largely

consistent with their belief systems. This suggests that incorporating religious beliefs into established therapeutic approaches may be an effective way to meet Muslims' needs in a therapeutic context.

An Islamic view of psychology. Australian participants recognised that practitioners would not necessarily view Islamic perspectives of mental illness as compatible with mainstream approaches. Indeed, they were concerned that practitioners would dismiss their religious beliefs as "ignorant", "backward", or "foreign". In contrast, concern about practitioners' perceptions were not mentioned by the Indonesian or Jordanian participants. This is not surprising, given that Muslims are a minority religious group in Australian society and practitioners would have less experience working with this population.

As noted by Renner and Salem (2014), clinical psychology is predominantly situated in diagnostic criteria and treatment modalities that have been based on research using Western samples. Further, several theorists (e.g., Adams, Dobles, Gómez, Kurtiş & Molina, 2015; Badri, 2000; Kaplick & Skinner, 2017; Sue & Sue, 1999; Trusty, Looby & Sandhu, 2002) have acknowledged that the disciplines of psychology and counselling are largely based on Western European ways of seeing the world. Mainstream models of mental health care generally revolve around Western European values, which focus on individuality, independence and personal autonomy. This is reflected in psychological treatments which see the development of the self as a core component of mental health (Norcross, VadenBos, & Freedheim, 2011). For individuals from collectivist cultures, such as many Muslim communities, this perspective may not be consistent with their religious beliefs, values, experiences and worldview. Islamic values tend to view obedience to God and family obligations as more important than self-focused interests (Das & Kemp, 1997). Rather than concentrate on the self, Islamic teachings drawn from the Quran and Prophetic traditions (*hadeeth*) emphasise pleasing God, self-sacrifice and collective social justice (Fischer, Ali,

Aydin, Frey & Haslam, 2010). Consistent with this emphasis, the participants indicated that they were mindful of their obligations to God and their families, especially their parents. Therefore, the ultimate goal of submitting to God superseded their individualistic desires.

That psychology has traditionally been based on Western viewpoints has led recent investigators to assert that there needs to be targeted research among other cultures (Jensen, 2011; Yamamoto, 2017). This has resulted in the emergence of cultural psychology, which is driven by the assumption that research findings and theories are culturally variable (Heine, 2012). Cultural psychology examines the role of culture in community phenomena and actively deconstructs notions of the 'other' based on the legacy of colonial relations. The focus of cultural psychology is to collaborate with people in diverse communities to understand their truth in their everyday experiences (Heine, 2012). Unfortunately, cultural psychology has yet to fully account for the perspectives of Muslims and the religious influences which tend to cut across different cultural and ethnic groupings.

Nevertheless, there is a growing awareness of the need for research which focuses on mental issues which are specific to Muslim populations. This is reflected by the establishment of a specialist journal that focuses on Muslim populations and promotes studies of mental health which are relevant for the Muslim community, the *Journal for Muslim Mental Health*. In addition, Islamic psychology has been proposed to represent Muslims' perspectives (Haque, Khan, Keshavarzi & Rothman, 2016; Kaplick & Skinner, 2017; Sahin, 2013). Islamic psychology acknowledges the critical role of religion and spirituality for Muslims in their perspective of mental health and effective treatment. It brings together two spheres of knowledge, the religious and the scientific. This includes identifying areas of mainstream psychology which are compatible, and those which diverge from sacred texts and scriptures. Islamic psychology acknowledges the relevance of religious beliefs in areas such as the aetiology of mental illness, assessment procedures, coping strategies, and treatment

approaches. Islamic psychology also gives scope for the development of psychological theories and treatment frameworks which accommodate Islamic concepts while remaining sensitive to Muslims' cultural and religious diversity (Haque et al., 2016).

It is important to note that Islamic conceptualisations of psychology are not new, dating back hundreds of years. Haque (2004) published a review of the works of Muslim scholars from the 9th and 12th centuries, indicating that psychology in the Muslim world preceded the modern world by over a century. Indeed, the classic spiritual and psychological works of 5th century Islamic scholar al-Ghazali are still used to develop contemporary theoretical frameworks in Islamic psychology.

There have been various attempts to revive Islamic psychology in the modern era. In his 1979 book *The Dilemma of Muslim Psychologists*, Badri encourages Muslim psychologists to draw on Islamic concepts and traditions rather than uncritically accept Western psychological theories and assumptions. More recently, Badri (2000) recommends that Muslim researchers and practitioners explore the rich cultural heritage of Islam in developing a knowledge base and framing the application of psychology. He argues that psychology can benefit from the contribution of Islamic perspectives concerning the role of faith and spirituality in the treatment of mental health conditions.

In 1990 the International Islamic University of Malaysia began to bridge the gap between Islam and modern psychology with the assistance of international scholars (Haque & Masuan, 2002). Other researchers and scholars have continued in these efforts to present psychological theories through the lens of Islam. For example, the text *Psychology of Personality: Islamic Perspectives* written by Haque and Mohamed (2009) describes Islamic concepts of soul, spirit, heart, human motivation and personality types. They use Islamic principles from the Quran, prophetic traditions and historical references to inform their

theoretical approaches. Despite the progress, more work is required to advance Islamic psychology. Haque et al. (2016) note that there is a rich history of Islamic texts relating to psychology which have yet to be translated and studied. Researchers such as Kaplick and Skinner (2017) argue that further development is needed to establish conceptual coherence in terms of definitions and a solid philosophical base.

Muslims' Help-Seeking Pathways

A crucial outcome of the research was the identification of stages of help-seeking, as depicted in the Muslims' Help-Seeking Pathways model outlined in Chapter 6. This provided an overview of the general processes through which practising Muslims seek assistance, in addition to the facilitators and barriers in accessing professional treatment services. The model outlines factors which are likely to be relevant to practising Muslims' dealing with emotional distress and indicates ways to improve their engagement with professional services. The stages identified include the recognition and identification of mental health problems, initial problem management, accessing mental health services, choosing a mental health practitioner, and experiencing mental health services. These stages are relatively consistent with previous studies of Muslims' help-seeking processes (e.g., Aloud & Rathur, 2009; Khan, 2006; Youseff & Deane, 2006). Even so, some additional areas for consideration were identified which are distinct from those reported by previous research. These include the participants' concerns regarding practitioners' knowledge of Muslims and Islam and their attitudes toward Muslims, the advantages and disadvantages of accessing treatment with a Muslim mental health practitioner, and the impact of participants' experiences accessing mental health services. Apart from the first step in the help-seeking process of recognising and being aware of mental illness, there were differences in each of the following stages between the participants from Australia and those who reside in

majority-Muslim countries. These differences were particularly evident in relation to the barriers to accessing professional mental health treatment.

Informal sources of support. It was found that initial responses to mental health difficulties tended to include seeking informal support from family and religious leaders. This is consistent with previous studies (e.g., Abu-Ras et al., 2008; Al-Darmaki, 2011; Aloud & Rathur, 2009; Al-Krenawi et al., 2000; Osman et al., 2005; Padela et al., 2012; Savaya & Cohen, 2005). Although this was evident for all participants, the participants from Indonesia and Jordan placed a greater emphasis on seeking help from family than the Australian participants._Considering the emphasis on family relationships in Islam, it is not surprising that the participants highlighted the role of family in managing personal problems and mental health issues. While consistent with religious and cultural values, at times this could be problematic. Several participants, including those from Australia, Indonesia and Jordan, relayed experiences where family members attempted to dissuade them from seeking professional treatment due to stigma-related concerns. This suggests that there are likely to be complex considerations regarding involving family members for an individual seeking mental health treatment. This requires that practitioners are able to understand the social context of the individual and how it can be supportive, whilst being mindful to sensitively navigate problems that can arise due to family involvement.

Across all the samples, religious leaders were considered to be a prominent source of assistance for mental health concerns. They were seen to provide religiously and culturally congruent support and assistance. Religious leaders were also a source of spiritual healing for practising Muslims with mental health difficulties. Nonetheless, the perceived lack of formal mental health training among religious leaders was cited as a key concern by the Australian participants, as it limited their ability to provide appropriate advice and referral information. Other researchers (e.g., Abu-Ras et al., 2008; Osman et al., 2005) have similarly

reported a lack of mental health training among religious leaders in Western countries. Given their status and access to the community, religious leaders are ideally placed to communicate accurate and helpful information to Muslims regarding mental illness and effective treatment pathways. Therefore, the training of Muslim leaders in mental health should be a priority in order to better equip them to assist their communities.

The central role of the family and religious leaders illustrates the need for practitioners to consider the social and religious context of the individual. They also need to understand that religious guidance and spiritual healing can be an integral part of problem management for practising Muslim clients. To date, the way in which these supports can be integrated with treatment frameworks has received limited attention (Abu-Raiya, 2013a).

Researchers such as Selkirk, Quayle and Rothwell (2014) have asserted that investigations into the help-seeking behaviours of culturally diverse groups in the West often employ Western models of help-seeking based on Western populations. Such models may not fully explain the help-seeking processes of religious-based groups such as Muslims. Two widely used help seeking models, the Theory of Reasoned Action (Ajzen & Fishbein, 1980; Fishbein & Ajzen, 1975) and the Health Belief Model (Rosenstock, 1966) do not account for the central role of religious beliefs for individuals with strong religious affiliation or with strong cultural and community contexts. For example, these models fail to adequately account for Muslims' emphasis on other forms of treatment which attend not only to the mind, but to the spiritual heart and the soul. Spiritual healing such as *ruqiah* (recitation of Quranic verses over an individual) may be accessed prior to, or in conjunction with, professional treatment. The failure of prevailing help-seeking and treatment models to recognise that such healing practices are legitimate forms of help points to the imposition of knowledge systems grounded in Western European values that have informed the assessment, diagnosis and treatment of mental disorders. The development of models of help-seeking

specific to Muslims, such as that presented in this research, provide a way to understand their unique help-seeking processes and more effectively identify their religious and cultural influences.

Religious perspectives on mental illness as a barrier. Despite the overall positive influence of religion upon mental health, participants were able to recognise interpretations of religious teachings which could be detrimental. They observed that the view that mental illness is due to supernatural causes can lead to a reluctance to access professional treatment. These perspectives were evident among the participants from majority-Muslim countries and those from Australia. Further, that mental illness reflects a weakness in one's faith could be demoralising for the sufferer. This appears to represent a form negative religious coping (Pargament, 1997) which has been associated with distress and poorer mental and physical health outcomes (Cole, 2005; Pargament, Koenig, & Tarakeshwar, 2001; Sherman, Simonton, Latif, Spohn & Tricot, 2005). Therefore, the role of religious perspectives for Muslims' mental health can be complex. Perhaps such beliefs become maladaptive when they are emphasised to the extent that other possible explanations are not considered. For practitioners, this highlights a need to be mindful that certain religious beliefs may have contradictory outcomes for mental health. Practitioners who explore these religious perspectives with clients in a curious and non-judgemental manner may assist their clients to identify the potential positive and negative outcomes.

Much of the literature on negative religious coping has tended to focus on the individual experience of engaging in a religious struggle (Abu-Raiya, Pargament & Exline, 2015). It would be useful for future research to adopt a broader view by exploring the ways that Muslim communities can sensitively address detrimental perspectives of mental illness whilst encouraging the use of positive religious coping responses.

Stigma. One of the barriers identified by the participants to Muslims accessing professional treatment is the stigma associated with mental illness. Stigmatizing attitudes are common in many societies around the world and can have a detrimental impact upon individuals with a mental illness (Crisp, Gelder, Rix, Meltzer, & Rowlands, 2000). This negative impact often extends to the family and friends of the individual (Luty, Fekadu, Umoh, & Gallagher, 2006).

According to the participants, stigmatizing attitudes result in a sense of shame for individuals in acknowledging their mental health problems and accepting the need for professional treatment. This is referred to as self-stigma where individuals internalise public attitudes (Chan & Mak, 2017). For example, the attitude that "people with mental illness are crazy" can result in individuals with mental illness believing that "I am crazy". The influence of stigma was particularly strong in the majority-Muslim countries of Indonesia and Jordan, and this extended across different socio-economic cohorts. These participants described highly negative perceptions of people with mental illness in their communities, as being 'crazy', 'dangerous', and unable to control their actions. The Indonesian and Jordanian participants noted that the public stigma was so prominent that individuals would struggle to accept that they have mental health problems as this would result in self-concurring with wide ranging negative assumptions (Chan & Mak, 2017). Similarly, Aloud and Rathur (2009) reported that stigma attached to mental illness and negative attitudes about seeking professional mental health treatment inhibited Arab Muslims in the United States from accessing mental health services. Youssef and Deane (2006) also found stigma to be a major obstacle for the utilisation of services by the Arab-speaking community in Australia.

While stigma was a concern for Australian participants, the level of self-stigma was more variable than in the Muslim-majority countries. This depended upon a range of factors, such as the individual's level of education, prior experience with mental illness and

professional treatment services, and level of acculturation. Participants considered that Muslims who are less acculturated to Australian society are more likely to be reluctant to access services due to self-stigma. Research has found a relationship between acculturation, stigma and mental health service utilisation with studies conducted in the United States showing that ethnic minorities and immigrant families are less likely to utilise mental health services compared to Caucasian families (Mendooza, 2009) and more likely to attempt to solve problems within the family (Pham, Carlson & Kosciulek, 2010).

The participants drew attention to the need for community education programs to reduce stigma towards mental illness among Muslims. Unfortunately, there is a lack of systematic evaluation in the literature of anti-stigma campaigns for minority groups. Even so, there is some evidence to suggest that education campaigns which are designed and delivered by key stakeholders within minority communities are likely to be most effective (Knifton, 2012).

Othering. Among the Australian participants, a barrier to accessing services was concern regarding the practitioners' ability to provide religiously and culturally competent treatment. Not surprisingly, this barrier was not evident among the participants from majority-Muslim countries and has received limited attention in research regarding Muslims and help-seeking. The Australian participants expressed doubts that practitioners would possess the religious and cultural knowledge necessary to build understanding and trust. Additionally, they described being fearful of the way in which practitioners would view practising Muslims. That they would be viewed as "extremist", that their beliefs and practices would be seen as "backward" or "ignorant", that Muslim women would be perceived as being oppressed, or that Muslim men would be regarded as violent.

Such fears were realised when practitioners made assumptions about practising Muslims and Islam, dismissed the significance of their faith, or offered solutions which were

in conflict with their beliefs and values. These issues are indicative of the effects of "othering" (Spivak, 1985; van der Veer, 2004) which refers to the social process where a particular group of people is perceived as being fundamentally different, or alien, in relation to existing social norms (Davies, 2004; Hall, 2003; Wilkinson & Kitzinger, 1996). According to the Australian participants, the "othering" stemmed from a lack of knowledge of Muslims and Islam in addition to adverse socio-political discourse and media representations. Due to this, participants were concerned that practitioners would have a general lack of awareness of the complex, diverse and heterogeneous characteristics of Muslims in Australia.

The experience of being regarded as "other" has been shown to have detrimental mental health effects, not only in creating obstacles to services but also through acts of discrimination and social exclusion (Bowes, 1993; Krieger, 1999; Krieger & Sidney, 1996; Potter, Brondolo & Smyth, 2017). In recent decades, there has been considerable discussion in relation to the "othering" of Muslims in the West. Particular attention has been paid to the language used in the media in reference to Muslims, often associating them with conflict, violence and terrorism (Ahmed & Matthes, 2016; Kassimeris & Jackson, 2011; Silva, 2017). Fears of "othering" in relation to accessing mental health services emerged as a noteworthy finding of this research. There has been a lack of attention to the impact of "othering" on Muslims in their daily lives and the potential ramifications for their mental health and access to treatment services (e.g., Aloud & Rathur, 2006; Khan, 2006; Youssef & Deane, 2006). Clearly, this is an area which requires further investigation.

Researchers such as Johnson et al. (2004) comment that education and promotion of cultural competence and sensitivity is necessary to challenge othering practices among health care practitioners. Further, they argue that it is essential that practitioners develop a critical consciousness of unintentional othering practices. This is consistent with the views of the

participants in this study, as they emphasised the need for practitioners to be reflexive about their interactions with Muslim clients. The findings of this research suggest that practitioners gaining accurate knowledge about Muslims and Islam, in addition to a stance of curiosity and respect, can counteract unintentional othering dynamics. In line with this, positive experiences with mental health services appeared to challenge fears associated with othering dynamics and encouraged participants to access mental health services. The impact of experiences with mental health services emerged as a crucial factor which can influence future help-seeking behaviours. Some of the positive experiences included feeling understood and respected during the treatment process, and finding the practitioner to be trustworthy, caring and non-judgmental. Treatment experiences were also deemed highly favourable when the practitioner possessed an awareness of Muslims' religious and cultural views and practices, or demonstrated an interest in understanding the way in which these beliefs and practices could be utilised in the treatment process.

The Importance of Religious and Cultural Competence

Acquiring relevant knowledge. Despite some positive experiences, almost 1 in 5 of the Australian survey respondents reported that they would not consider seeking professional help. A prominent concern raised by the Australian participants was that religious conceptualisations of mental health and illness would not be accommodated in treatment. As such, they questioned whether standard treatment would meet their needs. In this respect, interview participant Hanan described her experience with a psychologist as, "We had different minds ...."; and this resulted in her disengaging from treatment. The participants suggested that if their religious beliefs and values are incorporated into the treatment process, their engagement with services will improve. Therefore, it is important that practitioners who work with Muslim clients have religious and cultural training.

According to Sue et al. (1991), culturally competent counselling requires that practitioners first develop knowledge of the client's worldview, including culture-specific attitudes towards mental health issues, distinctive help-seeking behaviours, and the appropriateness of different counselling approaches. Second, that practitioners become more aware of their own culturally-informed attitudes, in addition to their beliefs about other cultures. This includes examining their cultural norms and worldview orientations, and questioning their own thoughts, feelings, values, attitudes and prejudices. Lastly, that practitioners recognise helping and healing practices outside the mainstream, Westernised counselling approaches. In addition to cultural considerations, some researchers have advocated for cultural competence to include an understanding of the religious and spiritual orientations of clients, which can be utilised to support treatment goals in ways that are consistent with clients' belief systems (Lukoff & Lu, 1999; Whitley, 2012). The inclusion of religious competencies is relevant for Muslim clients, particularly for those with high levels of religiosity.

Differentiating religious and socio-cultural issues is consistent with the distinctions identified by the participants. According to the participants, religious influences are those based in the sacred texts of the Quran and the *hadeeth* (Prophetic traditions). Examples of this include ways to perform acts of worship, such as the daily prayers and making supplications, practices which are considered to be compulsory, such as paying alms (*zakat*) and fasting in the month of Ramadan, and restrictions to behaviour such as abstaining from alcohol, or gaining monetary profits from interest and gambling. Socio-cultural influences, on the other hand, are those that originate from the society or community in which one is raised or resides. Such influences would include styles of clothes, types of food, communication styles and other practices or social norms which are not drawn from religious texts and teachings.

The emphasis on understanding religious and spiritual issues along with cultural competencies can be helpful in treating religiously orientated clients. This can assist practitioners to attend not only to the profound role of religion for clients during times of crisis and distress, but also to ways in which they can be sensitively incorporated in the treatment process. It should be noted that a risk that can arise in relying solely upon religious and cultural training to improve service provision is the assumption that one can truly "know" another's religion or culture (Dean, 2001; Johnson et al., 2004). An individual's religious beliefs and practice and cultural influences are not necessarily concrete, static, and relevant to all members of the group (Dueck, Ansloos, Johnson & Fort, 2016; Fisher-Borne, Cain, & Martin, 2014; Johnson et al., 2004; Laird, 1998). Therefore, the challenge remains for practitioners to avoid broad generalisations regarding their Muslim clients. This requires that they understand the nuanced lens through which their clients view their difficulties. Ideally, practitioners would not only understand Muslim clients' religion and culture, but also understand the unique experience of being a Muslim living in the West.

Therapeutic approaches to building trust. Across the samples, participants emphasised the need for practitioners to be respectful and empathetic. Accordingly, they saw trust as an essential part of their engagement with mental health services. This is unsurprising, given the concern expressed by Australian participants in relation to practitioners' perceptions of practising Muslims. Therefore, whilst religious and cultural competence requires the acquisition of specific knowledge and practical skills, a similar emphasis needs to be placed on the practitioner's manner and approach in building a therapeutic relationship.

A client-centred approach is likely to assist Muslim clients to feel understood. In counselling, seeking to understand the clients' perspective is rooted in humanism through the work of Rogers (1961). He emphasised the importance of understanding the phenomenology

of clients with their unique ethnic, religious, historic and social backgrounds. In this regard, a client-centred approach based upon Rogerian principles is likely to provide a useful basis for building the therapeutic alliance with Muslim clients. A central tenet of Rogers' approach is "person-centeredness" which aims to develop the alliance between the client and practitioner using the core attitudes of value, equality, respect and partnership (Biles, 2016; Rogers, 1961). This requires that the practitioner is able to listen attentively and engage with the client to develop a genuine empathic and caring relationship. Empathic understanding, it has been argued (Grant, 2010), cannot truly occur unless the practitioner can find a way to understand another's experiences and perspectives. A number of studies have provided support for the person-centred approach as an effective treatment for minority groups, including Muslims (Mohamed, Mokhtar & Samah, 2011; Quinn, 2012; Yoosefi, 2011). In the current research, the participants described practitioners positively when their effort to establish rapport was consistent with the Rogerian core conditions of counselling; therapist genuineness, unconditional positive regard and emphatic understanding. This approach is likely to meet the needs of Muslim clients by providing a safe environment for them to openly discuss their perspectives and experiences without fear of judgment (Whitey, 2012). A person-centred approach is likely to be useful to not only establish an effective therapeutic relationship, but also to help the practitioner to be receptive to the 'sacred lens' of their Muslim clients. This would enable the practitioner to better understand the needs of their clients, thus assist them to provide more relevant and responsive treatment. Once the therapeutic relationship is established, more structured treatment approaches may be useful to work toward therapeutic goals.

Practical Implications

Religiously integrated therapy. An important finding of the research is that the participants viewed that their religious beliefs and coping responses could be compatible with

mainstream therapeutic approaches. The benefits of treatment which incorporate religious and cultural values is supported by research conducted with a range of diverse groups (Cabassa & Zayas, 2007; Selkirk et al., 2014). This suggests that for practising Muslim clients, integrating religious and secular frameworks may be an effective way to provide treatment.

The findings provide examples of specific Islamic beliefs which could be incorporated into treatment. Participants utilised thought-challenging processes in their coping when they reframed their difficulties using faith perspectives. These Islamic beliefs may be helpful for Muslim clients to shift maladaptive thinking patterns into more adaptive viewpoints. These beliefs included pre-destination, framing problems as tests, the realisation that benefits may arise from difficulties, and that there can be a purpose or sense of meaning underlying struggles. Drawing upon such beliefs may be helpful for clients to challenge ruminative, negative thinking patterns in ways that are consistent with their religious views. The participants referred to sacred texts such as the Quran and Prophetic traditions for their coping responses which could be utilised in therapy. An example of this is from a Prophetic tradition which indicates that difficulties provide spiritual purification, "For any trouble, illness, worry, grief, hurt or sorrow which afflicts a Muslim, even the pricking of a thorn, Allah removes in its stead some of his sins." (Hadeeth, Sahih Al-Burhkari, 545). Quranic verses suggest that there can be beneficial outcomes through the experience of suffering: "It may be that you hate something and it is good for you, and you love something which is bad for you. Allah knows and you do not know" (The Noble Quran, 2:216). Other verses refer to difficulties being accompanied by ease, to provide a way to shift ruminative thinking and view a problem from an alternate perspective. For example, "Indeed, along with every hardship is relief" (The Noble Quran, 94:5).

Behavioural activation is used in psychological therapies to challenge unhelpful behavioural patterns and increase activity levels (Jacobson et al., 1996; Lewinsohn, 1975). The aim of behavioural activation is to increase engagement in valued activities which increases a sense of achievement and pleasure from life. For Muslim clients with high levels of religiosity, behaviours which they could see as helpful may include engaging in prayer, both individually and in congregation, specific supplications (*du'a*), reading the Quran, and attending community activities at local mosques or Islamic centres. These could be incorporated with other beneficial, non-religious behaviours such as exercising, socialising, and relaxation strategies.

Research supports the preference of religiously-orientated individuals to have their religious beliefs integrated into therapy (Koenig, Zaben & Al Shohaib, 2015; Martinez, Smith, Barlow, Pargament & Sanders, 2007; Stanley et al., 2011). Evidence is also available that demonstrates that religiously-integrated therapies are effective for a range of mental health problems (Koenig, 2012; Pearce & Koenig, 2013). Such therapies have achieved positive outcomes with Muslim samples (Azhar & Varma, 1996; Azhar, Varma & Dharap, 1994; Razali et al., 1998). A number of religiously-integrated approaches developed specifically for Muslim clients have been proposed. For example, Keshavarzi and Haque (2013) developed a treatment model incorporating Islamic concepts identified by prominent 11th century scholar Al-Ghazali. This model describes the four aspects of self; *qalb (*spiritual heart), *aql* (cognition), *nafs* (desires) and *ruh* (soul). The *qalb* (heart) is where the effects of the other three elements manifest. This model requires that the practitioner assesses which aspect requires the focus of the intervention (*aql, nafs, ruh*) in the goal of obtaining a healthy heart which allows one to live a meaningful life. Abu Raiya (2015) similarly developed an approach based on a Quranic theory of personality. These concepts may be readily understood by Muslim practitioners or those with an in-depth understanding of Islam. For

practitioners with a prior knowledge base, such frameworks could be used to engage and treat Muslim clients in ways that are meaningful for them. However, it may be unrealistic to expect practitioners who treat Muslim clients in the West to apply treatment models which are conceptually divergent from mainstream approaches.

A number of researchers (e.g., Azhar & Varma, 1996; Azhar, Varma & Dharap, 1994; Razali et al., 1998) have recommended modifying existing evidence-based treatment modalities to provide a more relevant and practical application of these therapies for Muslim clients. CBT is one approach which has been adapted to religious orientations (Hodge, 2011; Koenig et al., 2016; Pearce & Koenig, 2013). Religiously-integrated CBT (RCBT) adheres to the same principles and uses many of the same tools of CBT, however, the approach draws upon the client's religious traditions. For example, Pearce et al. (2015) outlines a RCBT approach for depression that involves the stages of behavioural activation, identifying unhelpful thoughts, challenging unhelpful thoughts, dealing with loss, coping with spiritual struggles and negative emotions, altruism and generosity, stress-related and spiritual growth, and hope and relapse prevention. The approach is promoted as being flexible in terms of the specific content being modifiable to the client's religious orientation. RCBT has been developed for clients with various religious orientations (e.g., Christian, Jewish, Muslim, Hindu, and Buddhist). However, the use of manualised treatment approaches for a range of different religious affiliations may be inappropriate in that there are likely to be differences in the way specific psychological and spiritual issues are dealt with across various faiths. The development of approaches specifically for Muslims are likely to provide a more relevant integration of religion into treatment. For example, Hamdan (2008) developed a model of CBT which adheres to the core principles of CBT but incorporates more detailed references from Islamic sources, thereby providing a more religiously and culturally compatible approach for Muslim clients.

Considerations for Treatment

The present research suggests that practitioners who engage Muslim clients in treatment will need to have some understanding of Islamic psychology. This is likely to be particularly pertinent as Muslim populations continue to grow in the West and increasingly require access to mental health treatment. An awareness of Islamic perspectives in psychology can provide practitioners with an understanding of their Muslim clients' views of mental illness and recovery. Furthermore, knowledge of the Islamic perspective can help practitioners to be cognisant of the assumptions of Western psychology and the ways in which these may lack relevance for Muslim clients.

The findings revealed a range of factors for the effective engagement of practising Muslim clients in therapy, as depicted in the framework presented in Chapter 7. These factors highlight the need for practitioners to possess underpinning knowledge of Muslims and Islam, and to approach their Muslim clients in a way which acknowledges the centrality of religion in their lives and builds a relationship of trust. The emphasis on practitioners being aware and respectful of the significance of Islam in clients' lives has been noted by other researchers (e.g., Abu Raiya & Pargament, 2011; Haque et al., 2016).

While most of the participants preferred that religious perspectives and coping behaviours be recognised as a part of the treatment process, there were some who deemed this unnecessary. Therefore, before proceeding with a religiously-integrated approach, it is important for practitioners to clarify with their Muslim clients whether they prefer to incorporate religious beliefs and practices into their treatment. This discussion at the beginning of treatment could explore the extent to which the client considers themselves to be religious and spiritual, whether religion has been helpful in coping with their problem, and possible ways to incorporate religious perspectives into treatment. Demonstrating an interest in the client's faith may help to clarify the role of religion or spirituality in their coping, assist

in building rapport and foster adherence to treatment. Giving Muslim clients the option of integrating religious healing practices into the therapeutic process is likely to communicate to the client that their beliefs and practices are respected and compatible with the treatment, which in turn is likely to increase compliance and improve therapy outcomes.

When Muslim clients do not express a preference for religious perspectives and practices to be combined with their treatment, the data suggests that it is still important for practitioners to be cognisant of the significant role of religion in a Muslim's life and coping with mental health problems. Additionally, it is useful for practitioners to be mindful of the social and cultural context of the client, particularly as Muslims tend to consider themselves as part of a larger family and cultural system with collectivist values (Gregg, 2007). An awareness of the role of family and community would assist professionals to be mindful of the ways in which the clients are interconnected with others and their roles and responsibilities within these systems.

Community-Based Initiatives

The participants described a range of community issues for Muslims relevant to their mental health needs. They stressed that targeting initiatives at the community level is needed to address these issues in ways that are religiously and culturally relevant for Muslims. Areas to be addressed were increasing awareness about mental illness and professional treatment services, the need for mental health training among religious leaders, and increasing the collaboration between mental health service providers and stakeholders in the Muslim community.

Public education programs. The participants identified a need for increased knowledge and awareness of mental illness within their communities. Identifying symptoms of mental illness was noted as an essential part of being able to recognise the need to access

treatment. Additionally, community education was proposed as a means to reduce stigma attached to accessing mental health treatment. In line with this, research suggests that public education can be an effective way to raise social awareness of mental illness and reduce community stigma (Corrigan et al., 2012). Examples of public education initiatives in Australia include information and training programs provided by organisations such as *beyondblue* and the *Black Dog Institute*. However, research indicates that education around mental illness needs to be tailored for minority groups if it is to be effective (Knifton, 2012). Public education campaigns should be available in the language of the target group and include visual imagery which represents their community. Awareness-raising events such as conferences or lectures should include speakers who are representatives from the community (Knifton, 2012). Furthermore, the Australian participants asserted that information about mental health should address specific issues which are relevant to the Muslim community, such as the Islamic perspectives of mental illness and its treatment. They also noted that topics should include those that are of concern for their community, such as parenting concerns, youth mental health, post-natal depression, major depression and anxiety. They suggested that information should be disseminated in places specific for Muslims, such as in mosques, Islamic centres and Islamic conferences and in ways that are relevant for their community. This could be delivered during weekly sermons or lectures and tailored to incorporate Islamic teachings, values and perspectives.

Training of religious leaders. Participants noted that Muslim leaders lack an understanding of the symptoms of mental illness and do not know where to refer individuals for appropriate treatment. Studies (e.g., Abu-Ras et al., 2008; Osman et al., 2005) have identified a lack of training among religious leaders in Western countries such as the United States. Research is needed in Australia to determine the level of mental health literacy of Muslim religious leaders and the impact of this on the community who seek their support.

There have been some training programs in Western countries for Muslim leaders. For example, in the United Kingdom, an organisation known as Inspirited Minds (http://inspiritedminds.org.uk) offers free mental health training for local imams. Similar programs have been delivered by mental health organisations for Muslims such as SMILE in the United States (https://www.smileforcharity.org). Whilst these initiatives indicate that there have been developments in the training of imams, research is required to determine their effectiveness. Available mental health training programs which are supported by research may be appropriate for Muslim religious leaders. For example, Mental Health First Aid **(**Clearly, Horsfall & Escott, 2015**)** provides training about the symptoms of mental health problems, appropriate first aid strategies, and how to provide first aid to individuals with mental illness until professional help is received. This training program could be modified to included aspects which address religious and cultural issues relevant for Muslims and their mental health. Considering the position of Muslim religious leaders within their communities, such training would enable them to provide appropriate support to community members who seek their assistance for mental health problems and equip them with referral information to direct Muslims to appropriate treatment services.

Strengths of the Research

This research includes a number of strengths. Primarily, it addresses a gap by giving voice to Muslims' views and experiences of mental illness and accessing treatment services. This is particularly valuable as research shows that Muslims perceive that they have been misrepresented in contemporary social-political contexts (Dunn et al., 2015; Hopkins, 2011).

The use of face-to-face interviews enabled me, as the researcher, to build trust with the participants and assisted them to be comfortable to express their views. Conducting both interviews and an online questionnaire provided the opportunity for participants to elaborate

their perspectives in both spoken and written form. Including participants with diverse educational, social, ethnic and cultural backgrounds helped to identify themes which were relevant across various groups, whilst also exploring the differences between these groupings. This study included participants residing in both Muslim-majority and Muslim-minority societies. This assisted in distinguishing between religious and cultural influences in the views of the participants.

The use of grounded theory as the method for data collection and analysis was particularly valuable. Although time-consuming, this approach was responsive to the emerging concepts without imposing pre-conceptions or having expectations of what would be found. This placed the participants' main concerns at the centre of the research and allowed for the final analysis to present the core concepts embedded in the data, whilst acknowledging the nuanced differences between the participants' views and experiences. This was reflected in the findings through the use of direct quotes, which kept the voices of the participants at the centre of the analysis.

A benefit related to a researcher position as part of the "in-group". As an identifiable Muslim, I was able to gain access to the Muslim participants in a range of settings. The interview participants reflected that they felt comfortable to share their views with a fellow Muslim and were confident that their perspectives and experiences would be understood and conveyed true to the meaning which they intended.

As recommended by Charmaz (2006), an in-depth review of the literature was not performed until after the data collection and analysis was completed. This ensured that the interpretation of the findings was not influenced by earlier writings. This also supported the validity of the conclusions drawn from the research as many of the findings were subsequently confirmed by previous studies.

Limitations of the Research

Despite these strengths, the research was not without limitations. The use of convenience samples, particularly for the interviews, may not have provided an accurate representation of Muslims generally. The sample sizes for the face-to-face interviews was relatively small. Therefore, it is difficult to make broad generalisations about such a large, heterogeneous group of people. Nonetheless, it is important to recognise that the sample size compared favourably with most other qualitative studies involving Muslims (e.g., Weatherhead & Daiches, 2010). Also, previous studies have tended to focus on one ethnic group (e.g., Aflakseir & Coleman, 2009; Ai, et al., 2003; Aloud & Rathur, 2009; Padela and Heisler, 2010; Youssef & Deane, 2006) whereas this research represented varied cultural and ethnic influences.

One limitation related to my position as a researcher in Indonesia and Jordan. There is a range of issues around conducting research as an outsider or partial outsider, particularly in terms of lacking an in-depth understanding of the nuances of the culture and community. In view of these issues, a number of actions were undertaken including the gathering of information about the community and their culture prior to collecting data, seeking connections with stakeholders and immersing myself in the community prior to conducting the research.

There were a number of limitations with the sample, particularly in terms of their age, with no participant aged over 50 years included in the interviews. Therefore, the views of older Muslims were not collected. Furthermore, no formal process was adopted to assess the mental health history of the participants. Although some of the participants self-reported a history of mental health difficulties, these reports were not verified through objective sources. A key limitation of such self-reports is that they assume that respondents have an accurate understanding of the symptoms of mental illness or that they have received an appropriate

diagnosis for a mental health condition. Therefore, such data must be taken with caution. Further, reliance on self-report data can leave research vulnerable to errors in participant recall and the possibility that participants present themselves or their community in a certain light (Patton, 2002). Providing the assurance of anonymity and using both face-to-face interviews and an online survey aimed to minimise these limitations.

The coding process did not utilise respondent validation, which requires that participants review the coding of the raw data to check the accuracy of analytical decisions (Seale, 1999). However, respondent validation is not always recommended. According to Glaser (2002), respondent validation provides an additional layer of data which needs to be analysed. Considering that coding is a time-consuming process, the added time required for further analysis of respondents' feedback of the analysis is likely to be impractical. Also, it has been argued that respondent validation is not necessary to determine the accuracy of the interpretations (Murphy, Dingwell, Greatback, Parker & Watson, 1998). This is likely to be the case for grounded theory studies, as analytical decisions are made by comparing data with data across a range of participant sources (Elliot & Lazenbatt, 2004). The grounded theory process of data analysis contains built-in methods to check the validity of the analytical decisions through the progressive processes of constant comparison. This allows for the inclusion of participants with different experiences in order to determine whether the findings hold as new data are collected. The methods of memo-writing and concept map construction provide continual reflexivity about the accuracy of analytical interpretations. In addition, these processes were supported by supervision.

As noted in Chapter 4, the data analysis process of grounded theory has been criticised for being subjective and reliant upon the abilities of the researcher (Suddaby, 2006). To limit the influence of bias I strove to remain close to the raw data throughout the analysis

and self-reflective about the analytical judgements which were made. This was a valuable approach to ensure that the conclusions drawn were grounded in the data.

Future Research Directions

This was an exploratory study with the aim to understand the participants' perspectives, attitudes and experiences in regard to mental illness and accessing professional treatment. A range of key areas were identified including the central role of religion in their lives and in their responses to mental illness, their distinct help-seeking pathways and the inclusion of cultural and religious sensitivity in treating Muslim clients. These findings point to a range of areas which require further research.

One area which is lacking is that of accurate mental illness rates among Muslim populations. National census data do not include information about mental illness based on religious affiliation. As such, the rate of mental illness among Muslims across Western societies, including Australia, New Zealand, the United States and Europe is unknown. This is concerning, particularly as Muslims living in Western nations are subject to a range of inequalities and stressors which are likely to exacerbate mental health problems. Additionally, there is a lack of large scale, quantitative research which investigates service utilisation among Muslim populations in the West. This makes it difficult to determine whether there is an unmet need for mental health treatment among Muslims or greater investment is required to enhance access to mental health treatment.

The research illuminated several important issues in regard to Muslims and the ways in which their religious beliefs shape their conceptualisation of mental health and illness, their coping responses, and their help-seeking pathways. Ongoing inquiry is needed to develop and assess treatment approaches that incorporate Muslims' religious beliefs and practices. A number of researchers have proposed religiously-incorporated treatment models for Muslims, yet there is limited research regarding the effectiveness of such approaches.

Although participants expressed concern about a lack of religious and cultural knowledge among practitioners, the actual knowledge base and competence of practitioners who treat Muslim clients is unknown. This requires investigation. The current research identified religious and cultural competencies for treating Muslim clients and this could be furthered developed and included in training programs for practitioners. Follow-up evaluation is required in order to determine the effectiveness of such programs.

This research focused on the perspectives and experiences of practising Muslims. It is therefore not known whether the perspectives of non-practising Muslims would differ substantially from those of practising Muslims. Investigations which compare these two groups would be of value. Such research could inform the development of effective treatment approaches for Muslims of varying levels of religiosity.

Another area which requires further investigation is the role of acculturation in the help-seeking process. Although the participants perceived that Australian Muslims with higher levels of acculturation are more willing to access mental health services, the relationship between these factors is unclear. Research in this area would need to clearly define acculturation levels in order to then determine the impact on help-seeking processes whilst taking into account other potential mediating variables, such as gender, age of migration, religiosity, education level, and prior experiences with mental illness and professional treatment services. Longitudinal research would be ideal to shed light on the impact of the acculturation process on stigmatizing attitudes. Such research needs to take into account important differences between immigrant groups, such as previous mental health conditions and experiences with mental health treatment. It would be particularly valuable to investigate the ways in which Muslims' coping behaviours change over the course of their resettlement and through the stages of acculturation.

Australian Muslim religious leaders are well placed to provide mental health support and referrals for the Muslim community. However, they appear to lack relevant training. Although there have been training programs developed for religious leaders in countries such as the United States, United Kingdom and Australia, they have had limited reach and there is little research regarding their efficacy. Clearly, research is required to further develop and evaluate such programs.

There is also a need for information-based programs to target Australian Muslims regarding the typical symptoms of mental illness and effective treatment approaches. This could be developed in partnership with Muslim organisations. Research is needed to evaluate the effectiveness of these programs in terms of raising awareness of mental health, reducing stigma, and facilitating access to mental health services.

Considering the social and political issues associated with Muslims in Australia and other Western countries, Muslims can have reservations about participating in research. Therefore, it would be helpful to include Muslim researchers in future studies in order to build trust. Involving members of the "in-group" as part of the research team can be valuable to engage the Muslim community. Furthermore, it is recommended that further research adopts a mixed-methods design. Including quantitative data can be useful, as this allows for the use of standardised measures and enables analyses to investigate relationships between variables in large samples. Meanwhile, utilising qualitative methods is particularly valuable in order to maintain a connection to the lived experiences and perspectives of Muslims.

Conclusion

This study began with broad, exploratory questions. Through the research process, the participants drew attention to issues which they considered to be most pertinent for Muslims with regards to mental health and illness and accessing professional treatment services. The first main finding highlighted the distinct lens through which Muslims view

their experiences, including mental health and illness, and the compass which guides their actions and behaviours. This showed that for Muslims, religious and spiritual beliefs are fundamental for their daily living, and for their understanding of and responses to mental health and illness. The distinct help seeking pathways of Muslims identified that in addition to religious perspectives, social and cultural factors influence their response to mental health problems and the type of help which is sought. These findings pointed to a range of barriers for Muslims in accessing professional mental health treatment. That practitioners gain religious and cultural knowledge was emphasised by the participants so that they could understand the perspectives and experiences of Muslim clients.

This research is unique in that it is one of the first studies to provide an in-depth exploration of Muslims' perspectives and experiences of mental illness and accessing treatment services across three social contexts. This exploration illuminated areas which can be addressed to better meet Muslims' mental health needs. Given that research about Muslims' lived experiences of mental health and illness has been limited, this study provided an opportunity for Muslims' voices to be heard and their experiences understood, through their eyes.

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Appendix A. Information letter for interview participants

St Patrick's Campus
115 Victoria Parade
Locked Bag 4115 Fitzroy MDC Fitzroy Australia
Email: Ljverw001@myacu.edu.au

INFORMATION LETTER TO PARTICIPANTS

TITLE OF PROJECT: Exploration of attitudes among Muslims towards mental health service providers

SUPERVISOR: Dr. Cecelia Winkelman

STUDENT RESEARCHER: Lucy Verwey

PROGRAMME IN WHICH ENROLLED: Doctor of Philosophy (Psychology Department).

Dear Participant,

You are invited to participate in a project researching the attitudes, perceptions and experience among Muslims towards mental health service providers in Australia. This research is being conducted towards a Doctor of Philosophy (Psychology department). For this project, we are interested in the perceptions, experiences and attitudes of Muslims towards mental health service providers such as counsellors, psychologists, psychiatrists, and the services provided in both public and private mental health services. We are particularly interested in whether you believe that mental health service providers are properly equipped to provide effective services for Muslim clients. For this study, a number of participants will be interviewed individually. These interviews will be audio taped. It is possible that the interview will raise topics of your previous experiences, or experiences of others you know, as a client with a mental health professional. The individual interviews will involve approximately 1 hour of interview time.

It is hoped that the study will help aid the understanding of the needs of Muslims in the context of providing mental health services. The study may reveal important areas that can improve the provision of services to Muslims, such as up-to-date training of mental health professionals to deal

effectively with Muslim clients. It is hoped that the results of the research will be published in an academic journal and presented at conferences upon completion.

You are free to refuse consent to participant in the study without having to justify the decision or to withdraw consent and discontinue participation in the study at any time without giving a reason.

Confidentiality will be protected throughout the research. Your identity will be protected and will not be revealed at any stage during or upon completion of the study. The original transcripts and audio tape of the interview will be kept in a secure location and will not be available for public access.

There are no foreseen risks in participating in the research project, however should you have the need to contact a counsellor, a list of available counsellors can be provided.

Any questions regarding the project should be directed to the Supervisor and the Student Researcher:

Lucy Verwey

Student Researcher

Ph: 0406 209 160

Email: Ljverw001@myacu.edu.au

Cecelia Winkelman

Supervisor

Department of Psychology

Locked Bag 4115 Fitzroy MDC Fitzroy Australia

Email: Cecelia.Winkelman@acu.edu.au

If you would like feedback on the results of the project, this will be provided to you upon request.

This study has been approved by the Human Research Ethics Committee at Australian Catholic University. If you have any complaint or concern regarding the study, or if you have any query that the Supervisor and Student Research have not been able to satisfy, you may write to the Chair of the Human Research Ethics Committee.

VIC: Chair, HREC
C/- Research Services
Australian Catholic University
Melbourne Campus
Locked Bag 4115
FITZROY VIC 3065
Tel: 03 9953 3158
Fax: 03 9953 3315

Any complaint or concern will be treated in confidence and fully investigated. You will be informed of the outcome.

If you agree to participate in this project, you should sign both copies of the Consent Form, retain one copy for your records and return the other copy to the Student Researcher.

Appendix B. Consent form for interview participants (participant copy)

St Patrick's Campus
115 Victoria Parade
Locked Bag 4115 Fitzroy MDC Fitzroy Australia
Email: Ljverw001@myacu.edu.au

CONSENT FORM
Copy for Participant to Keep

TITLE OF PROJECT: *An Exploration of the Attitudes, Perceptions and Experiences of Muslim Australians towards Mental Health Services*

SUPERVISOR: Cecelia Winkelman .....

STUDENT RESEARCHER: Lucy Verwey.....

I ..... *(the participant)* have read and understood the information provided in the Letter to Participants. Any questions I have asked have been answered to my satisfaction. I agree to participate in this interview for the duration of approximately 1 hour which will be audio taped, realising that I can withdraw my consent at any time. I agree that research data collected for the study may be published or may be provided to other researchers in a form that does not identify me in any way.

NAME OF PARTICIPANT: .....

SIGNATURE ..... DATE

.....

SIGNATURE OF STUDENT RESEARCHER: .....

DATE:.....

Appendix C. Consent form for interview participants (researcher copy)

St Patrick's Campus
115 Victoria Parade
Locked Bag 4115 Fitzroy MDC Fitzroy Australia
Email: Ljverw001@myacu.edu.au

CONSENT FORM
Copy for Researcher to Keep

TITLE OF PROJECT: *An exploration of attitudes, perceptions among Muslims towards mental health services in Australia* .....

SUPERVISOR: Cecelia Winkelman .....

STUDENT RESEARCHER: Lucy Verwey .....

I ..... *(the participant)* have read and understood the information provided in the Letter to Participants. Any questions I have asked have been answered to my satisfaction. I agree to participate in this interview for the duration of approximately 1 hour which will be audio taped, realising that I can withdraw my consent at any time. I agree that research data collected for the study may be published or may be provided to other researchers in a form that does not identify me in any way.

NAME OF PARTICIPANT: .....

SIGNATURE ..... DATE .....

SIGNATURE OF STUDENT RESEARCHER: .....

DATE:.....

Appendix D. Introductory statement for online survey

Mental Health Services for the Muslim Community

Assalamuwalikum

Dear Participant,

Thank you for participating in this research study. Your responses are important and appreciated. This questionnaire is about your personal opinions and experiences in relation to mental health services for Muslims. Mental health services include those provided by psychologists, counsellors, social workers, psychiatrists and other mental health workers. It is an opportunity for you to express your opinions about the effectiveness of mental health services for the Muslim community.

It is hoped that the findings of this study will help facilitate appropriate support for Muslims in need of counselling and other mental health services.

It will take you approximately 20 minutes to complete the questionnaire.

There are no right or wrong answers. I am seeking your honest thoughts and opinions.

This is an anonymous questionnaire. Your name is not required, unless you choose to mention it for the purpose of arranging a follow-up interview.

Please note that whether you provide your name or not, your confidentiality is guaranteed. Your name will not be mentioned in the final report of this research project.

The research is done at the School of Psychology at the Australian Catholic University. The results of this questionnaire will form part of my PhD thesis and may also be presented in academic journals and conferences. The research project has HREC approval (V2010 13). If you have any queries regarding the questionnaire or the research project, please contact me on ljverw001@myacu.edu.au.

Your participation is very much appreciated. Thank you!

Sr. Lucy Verwey.

Appendix E. Information flier for online survey

Research: Muslims and Counselling and Mental Health Services.

Assalamwalikum wa rahmatullahi wa barakatu,

My name is Lucy Verwey and I am a Muslim revert undertaking my PhD. I am currently seeking Muslims living in Australia to complete my online survey as part of my research. My study is researching the attitudes, perceptions and experiences of the Muslim community towards counselling and mental health services in Australia. If you are a Muslim living in Australia and have time to complete my online questionnaire I would greatly appreciate it. Thank you!

Survey link:

https://www.psychdata.com/s.asp?SID=143977

Jazakallahu khayrun,

Sr. Lucy.

lucyverwey@y7mail.com